Supreme Court, U.S.
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No. ——

IN THE

Supreme Court of the United States

AMERICAN MEDICAL SECURITY, INC.,
Petitioner,

v.

SKILSTAF, INC.,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

PETITION FOR WRIT OF CERTIORARI

PAUL J. ONDRASIK, JR.
Counsel of Record
ERIC G. SERRON
STEPTOE & JOHNSON LLP
1330 Connecticut Avenue, N.W.
Washington, D.C. 20036
(202) 429-3000
Attorneys for Petitioner

WILSON-EPES PRINTING CO., INC. – (202) 789-0096 – WASHINGTON, D. C. 20001

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QUESTIONS PRESENTED

1. Whether Section 514(a) of the Employee Retirement Income Security Act ("ERISA") preempts state law claims, including a claim for punitive damages, brought by a self-funded employee benefit plan's sponsor against the plan's third-party administrator arising out of the administrator's processing of benefit claims.

2. Whether Section 514(a) of ERISA preempts state law claims, including a claim for punitive damages, based upon alleged self-dealing and conflicts of interest in the processing of benefit claims by a third-party administrator responsible for reviewing denied claims under an employee benefit plan's statutorily-mandated claims procedure.

PARTIES TO THE PROCEEDING BELOW

Plaintiff

Skilstaf, Inc.

Defendants

American Medical Security, Inc.

United Wisconsin Life Insurance Company

RULE 29.6 STATEMENT

Pursuant to Supreme Court Rule 29.1, Petitioner American Medical Security, Inc. discloses that its parent is American Security Holdings, Inc., which in turn is a wholly owned subsidiary of American Medical Security Group, Inc. Blue Cross and Blue Shield of Wisconsin owns 44.9 percent of American Medical Security Group, Inc.'s stock. Blue Cross and Blue Shield of Wisconsin is a wholly owned subsidiary of Cobalt Corporation.

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120 Cong. Rec. 29,933 (1974) 6, 18

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PETITION FOR A WRIT OF CERTIORARI

Petitioner American Medical Security, Inc. ("AMS") respectfully prays that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Eleventh Circuit entered on March 9, 2001.

OPINIONS AND ORDERS BELOW

The unpublished decision of the court of appeals is reported at 251 F.3d 163 (table) and is reproduced in the Appendix ("App.") at 3a to 4a. The Eleventh Circuit's unpublished order denying AMS's petition for rehearing is available at 2001 U.S. App. LEXIS 15575 and is reproduced at 1a to 2a. The unpublished orders and judgment of the United States District Court for the Middle District of Alabama are reproduced at 5a to 48a.

JURISDICTION

The judgment of the court of appeals was entered on March 9, 2001. Its order denying Petitioner's timely petition for rehearing *en banc* was filed on May 4, 2001. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

This case involves Sections 3(21)(A)(iii), 404(a)(1)(A), 406(b), 502(a), 503, and 514(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1002(21)(A)(iii), 1104(a)(1)(A), 1106(b), 1132(a), 1133, and 1144(a), and 29 C.F.R. § 2560.503-1 promulgated under Section 503 of ERISA. These provisions are reproduced at 49a to 64a.

STATEMENT OF THE CASE

The sponsor of an employee benefit plan brought state law claims against AMS, a third-party administrator responsible for administering the plan's ERISA-mandated benefit claims

review procedure. The state law claims included claims for breach of fiduciary duty and "wantonness" based on AMS's alleged systematic delay in processing benefit claims to benefit itself financially. The case was tried before a jury in August 1999, the district court having previously rejected AMS's argument that ERISA preempted plaintiff's state law claims. The jury awarded plaintiff $6,902,576, which included $1,422,576 in compensatory damages on the fiduciary breach claim and $5,000,000 in punitive damages on the "wantonness" claim.

A. Facts

Respondent Skilstaf's predecessor, Stafco, Inc. (hereafter "Skilstaf"), established a self-funded employee benefit plan ("Plan") to provide health care benefits to its employees. In September 1992, Skilstaf entered into an Administrative Services Agreement ("Agreement") with petitioner AMS.

Under the Agreement, AMS agreed to prepare a summary plan description for the Plan's participants, secure excess loss insurance for Skilstaf, and perform certain administrative functions with respect to the Plan. AMS's administrative functions included: processing benefit claims; paying benefits from an account funded by Skilstaf; maintaining records and preparing reports of transactions between Skilstaf, AMS and Plan participants; pursuing subrogation claims; notifying participants of the reasons for claim denials and of their right to have the denials reviewed; and reviewing denied claims under a procedure designed to satisfy ERISA.

The summary plan description ("SPD") informed participants of their rights under the Plan and of AMS's procedures for processing and adjudicating claims. In an SPD section entitled "Statement of Your ERISA Rights," participants were informed that, "[w]ith respect to paying claims for benefits under this Plan, [AMS] shall have discretion to interpret policy terms, make decisions regarding eligibility and resolve factual questions."

Another SPD section, entitled "Claim Procedures," provided that participants would be notified of the decision on their claim for plan benefits within 30 days of AMS's receipt of the claim. The section also stated that participants would be informed of the reasons for any claim denial and given an explanation of the Claim Appeal Procedure. Later, under the heading "Legal Actions," participants were advised that, if a dispute arose:

> [AMS] will resolve such dispute by appropriate consideration of all available evidence. All determinations are conclusive, final, and binding; unless they are successfully appealed under the Claim Appeal Procedure. You cannot bring an action against the Plan or [AMS] at law or in equity to recover a claim or damages until more than 60 days after the Claim Appeal Procedure is completed. . . .

In another SPD section, entitled "Claim Appeal Procedure," participants were informed that an appeal request had to be sent to AMS within 60 days after receipt of a notice of claim denial. Participants would receive written notice of any decision within 60 days (in special circumstances, up to 120 days) of AMS's receipt of an appeal request. Participants then would have 60 days from the date they received this notice to request a second appeal to a special panel. The special panel was to notify participants in writing of its final decision within 60 days (in special circumstances, up to 120 days) of receiving the second appeal.

The SPD section describing the Claim Appeal Procedure concluded as follows:

> [AMS] will interpret the Plan, and determine all inquiries arising in the administration, application, and interpretation of the Plan in good faith and consistent with the Plan. In any case, you must exhaust all available appeals before taking any legal action.

The SPD did not establish, much less require participants to exhaust, a third-level appeal to Skilstaf.

The Agreement confirmed that no appeal to Skilstaf was contemplated. It provided that AMS (*not* the participants) would refer to Skilstaf:

> any disputed claim (*after the appeal process under the Plan has been completed*); any question of eligibility or entitlement of the claimant for coverage under the Plan; and any other question as AMS deems necessary. The PLAN SPONSOR acknowledges that any claim which it requests to be paid on an 'out-of-Plan' basis will not be considered Plan benefits reimbursable under the Excess Loss Insurance Policy.

(Emphasis added).

AMS arranged for Skilstaf to obtain excess loss insurance from United Wisconsin Life Insurance Company ("UWLIC"). AMS had a number of financial relationships with UWLIC, including a partial reinsurance arrangement through an AMS subsidiary.

Under the excess loss policy, UWLIC agreed to reimburse Skilstaf for "eligible medical claims under the Plan in excess of certain specific and aggregate amounts." However, UWLIC had no obligation to reimburse Skilstaf under the policy unless an expense was incurred and paid during the policy term. If the policy terminated during a policy term, no claims, including those already paid by AMS, would be eligible for excess loss coverage. By its express terms, the policy would terminate upon cancellation of Skilstaf's Agreement with AMS. Effective May 31, 1996 and prior to the end of the policy's term, Skilstaf canceled the Agreement, which resulted in termination of the excess loss policy.

B. Proceedings Below

On January 22, 1998, Skilstaf filed this action against AMS in the United States District Court for the Middle District of Alabama, invoking jurisdiction under 28 U.S.C. § 1332. Skilstaf's amended complaint included state law claims for breach of contract, negligence, "wantonness" and breach of fiduciary duty arising out of AMS's conduct in performing its administrative responsibilities with respect to the Plan. In the district court, Skilstaf maintained, among other things, that AMS intentionally delayed processing benefit claims to protect its subsidiary against excess loss liability as UWLIC's reinsurer. Skilstaf's claims for breach of fiduciary duty and "wantonness" were premised on this alleged conflict of interest and self-dealing. No ERISA claims were asserted against AMS.

In a summary judgment motion, AMS argued that Skilstaf's state law claims were preempted by ERISA. Skilstaf acknowledged that: "As an ERISA fiduciary of the Plan, Skilstaf could avail itself of the provisions of ERISA regarding breach of fiduciary duty by the Defendants and certainly has viable remedies under ERISA that it could pursue against the Defendants." Skilstaf, Inc.'s Response to Defendants' Reply Brief (June 18, 1999) at 3 n.3. Yet Skilstaf insisted that it could pursue "available state law remedies against the Defendants, although it certainly would not be precluded from asserting an ERISA cause of action against the Defendants in addition to its state law claims." *Id.*

In denying summary judgment, the district court rejected AMS's preemption argument, reasoning that "AMS is not an ERISA entity and the state law claims against it do not sufficiently relate to the employee benefit plan to be preempted by ERISA." App. at 33a. Skilstaf's state law claims were tried to a jury. AMS moved at the conclusion of the evidence for a directed verdict, again arguing that plaintiff's claims were preempted. The motion was denied,

and the jury returned a verdict against AMS for $6,902,576, including $6,422,576 in compensatory and punitive damages on the breach of fiduciary duty and "wantonness" claims. App. at 21a-22a. The district court thereafter denied AMS's motion for judgment as a matter of law, a new trial and/or remittitur, rejecting again AMS's argument that the state law claims were preempted. App. at 11a.

AMS appealed the district court's rulings to the United States Court of Appeals for the Eleventh Circuit. On March 9, 2001, a panel of the Eleventh Circuit affirmed the district court's rulings in an unpublished *per curiam* decision. App. at 3a-4a. AMS then filed a petition for rehearing *en banc*, which the Eleventh Circuit denied on May 4, 2001. App. at 1a-2a.

REASONS FOR GRANTING THE PETITION

This Court has taken notice of "the centrality of pension and welfare plans in the national economy, and their importance to the financial security of the Nation's work force."[1] In enacting ERISA to protect the interests of participants and beneficiaries in these plans, Congress expressly intended to make employee benefit plan regulation a "matter of exclusive federal concern."[2] One of Congress's principal goals in drafting ERISA was the elimination of the conflicting system of state and local regulation then governing the employee benefit field.[3] In its place, Congress substituted a single federal regulatory scheme governing the operation and administration of employee benefit plans. ERISA, as finally enacted, imposes uniform standards of

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[1] *Boggs v. Boggs*, 520 U.S. 833, 839 (1997).

[2] *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981).

[3] H.R. Rep. No. 93-533 at 12 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4650 ("H.R. Rep. No. 93-533"); 120 Cong. Rec. 29,933 (1974) (remarks of Sen. Williams).

conduct on fiduciaries,[4] establishes a comprehensive civil enforcement scheme,[5] and requires every employee benefit plan to adopt an internal procedure for the orderly resolution of benefit claims.[6]

ERISA's preemption provision—referred to in the legislative history as the statute's "crowning achievement"[7]—was meant to ensure that this new federal framework remained preeminent. With narrow exceptions, ERISA § 514(a) expressly preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . ."[8] The "basic thrust" of this preemption provision is "to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans."[9]

Consistent with this objective, this Court has found state laws preempted where they purport to regulate the administration of plans or provide alternate enforcement mechanisms for breach of ERISA obligations.[10] Nonetheless, the scope of ERISA's preemption of state law has remained a source of confusion. Indeed, since its first foray into this area in 1981, this Court has been required to address ERISA's preemptive scope on eighteen separate occasions—most recently, last term in *Egelhoff v. Egelhoff ex rel. Breiner*, 121 S. Ct. 1322 (2001)—and already it has decided to hear still another ERISA preemption case on the merits this

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[4] ERISA §§ 401-14, 29 U.S.C. §§ 1101-14.

[5] ERISA § 502(a), 29 U.S.C. § 1132(a).

[6] ERISA § 503, 29 U.S.C. § 1133.

[7] 120 Cong. Rec. 29,197 (1974) (remarks of Rep. Dent).

[8] 29 U.S.C. § 1144(a).

[9] *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 657 (1995).

[10] *Id.* at 657-58.

term. *Rush Prudential HMO, Inc. v. Moran*, 230 F.3d 959 (7th Cir. 2000), *cert. granted*, 121 S. Ct. 2589 (2001).[11]

The Eleventh Circuit's decision once again calls on this Court to address this central feature of ERISA's statutory scheme, this time in the context of an important member of the employee benefit plan community—the third-party administrator. Respondent's state law claims—alleging that Petitioner failed to timely process benefit claims—intrude directly into the plan's "'system for processing claims and paying benefits'" and impose "'precisely the burden [on plan administration] that ERISA pre-emption was intended to avoid.'"[12] In addition, Respondent's breach of fiduciary duty and "wantonness" claims accused Petitioner of intentionally delaying the processing of claims to benefit itself financially. Such conduct is tantamount to an ERISA fiduciary "self-dealing" violation,[13] for which the remedies provided by ERISA's civil enforcement scheme were intended to be exclusive.[14]

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[11] *Moran* involves state intrusion into ERISA's regulatory framework and civil enforcement scheme (including the plan's claim review procedures) similar to that here presented—a provision of a state HMO law which requires disputes over medical necessity to be submitted to independent physician review. The Court also has called for the views of the Solicitor General in yet another ERISA preemption case in which a petition for certiorari is pending—*Kentucky Ass'n of Health Plans, Inc. v. Nichols*, 227 F.3d 352 (6th Cir. 2000), *petition for cert. filed*, 69 U.S.L.W. 3646 (Mar. 22, 2001) (No. 00-1471) (whether ERISA preempts state "any willing provider" law). *See* 121 S. Ct. 2546 (2001) (interim order inviting the Solicitor General's views).

[12] *Egelhoff*, 121 S. Ct. at 1329 (quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 10 (1987)).

[13] *See* ERISA §§ 404(a)(1)(A) & 406(b), 29 U.S.C. §§ 1104(a)(1)(A), 1106(b).

[14] *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142-45 (1990) (participant's state common law claim alleging wrongful discharge to

The Eleventh Circuit's decision allowing these state law claims to survive undermines ERISA's comprehensive regulatory framework and the important principles of uniformity upon which it is based. Furthermore, it conflicts with this Court's ERISA preemption jurisprudence and the Fourth Circuit's decision in *Tri-State Machine, Inc. v. Nationwide Ins. Co.*, 33 F.3d 309 (4th Cir. 1994), *cert. denied*, 513 U.S. 1183 (1995). Finally, the case is illustrative of the numerous cases in the lower courts that have addressed ERISA's preemption of state law claims against third-party administrators with differing results and rationales. The intervention of this Court is essential to provide clarity on an issue of law that is of critical importance to a segment of the employee benefit plan community that is responsible for processing literally millions of claims for plan benefits annually.

I. THE ELEVENTH CIRCUIT'S DECISION ALLOWS STATE LAW STANDARDS TO INTRUDE INTO THE CLAIMS PROCEDURE MANDATED BY ERISA

The Eleventh Circuit's decision frustrates a central goal of ERISA's statutory framework—enabling the establishment of "'a uniform administrative scheme, which provides a set of standard procedures to guide [the] processing of claims and disbursement of benefits.'" *Egelhoff*, 121 S. Ct. at 1328 (quoting *Fort Halifax*, 482 U.S. at 9). Under Section 503 of ERISA, all employee benefit plans must establish claims procedures that comply with Department of Labor regulations. 29 U.S.C. § 1133; *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 53 (1987); *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 143-44 (1985). The regulation promulgated by the Department of Labor requires every

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prevent his attainment of plan benefits was preempted because it conflicted with ERISA's civil enforcement scheme).

employee benefit plan to establish "reasonable" claims procedures and specifies a host of conditions that must be satisfied. 29 C.F.R. § 2560.503-1(b).

Among other things, the Department's regulation requires plans to furnish participants with written notice of any claim denial within a reasonable time after the plan's receipt of the claim. 29 C.F.R. § 2560.503-1(e)(1). A time period exceeding 90 days is deemed unreasonable absent special circumstances. 29 C.F.R. § 2560.503-1(e)(3). If an extension of time is needed, written notice must be provided to the claimant within the initial 90-day period, and the extension itself cannot exceed 90 days. *Id.*

Under ERISA § 503(2) and 29 C.F.R. § 2560.503-1(g)(1), every employee benefit plan also is required to establish a procedure by which a claimant can obtain a "full and fair" review of an adverse benefit decision by "an appropriate named fiduciary." The Department's regulation provides that a decision on review must be made "promptly," ordinarily within 60 days after the plan's receipt of the request. 29 C.F.R. § 2560.503-1(h)(1)(i). If special circumstances require an extension of time, a decision on review must be rendered as soon as possible, but not later than 120 days after receipt of a request for review. *Id.*

The Plan's SPD in this case included a detailed description of its ERISA-mandated claims procedure.[15] The SPD

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[15] ERISA requires a summary plan description to be furnished to the plan's participants and beneficiaries. ERISA § 101(a)(1), 29 U.S.C. § 1021(a)(1); *see Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 83 (1995) (purpose of summary plan description is "to communicate to beneficiaries the essential information about the plan"). This summary plan description must include, among other things, a description of the plan's procedures for presenting claims and the remedies available under the plan for redressing denied claims, including the claims procedures mandated by ERISA § 503. ERISA § 102(b), 29 U.S.C. § 1022(b); *see also* 29 C.F.R. § 2560.503-1(b)(1)(ii) (to be deemed

informed participants that they would be notified of the decision on their claim within 30 days of Petitioner's receipt of the claim. Under the Department's regulation, a participant's claim would be deemed denied if Petitioner failed to notify the participant of a denial within a "reasonable" time. 29 C.F.R. § 2560.503-1(e)(2). The SPD further informed participants that they could seek review of any denied claim through the Plan's Claim Appeal Procedure, and included a detailed description of the procedure and the applicable time frames.

The Eleventh Circuit's decision would allow state law standards to interfere with the claims procedure mandated by ERISA. Respondent's state law causes of action required Petitioner to adhere to an ill-defined "timeliness" standard in processing claims that was untethered to the time limits specified in the SPD and 29 C.F.R. § 2560.503-1. ERISA's pervasive regulation of the employee benefit plan claims procedure necessarily displaces state law causes of action like Respondent's alleging untimely processing of benefit claims.[16] The goal of ensuring uniformity in plan

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reasonable, claims procedures must be described in the summary plan description).

[16] In its new claims procedure rules under ERISA § 503, the Department of Labor expressly acknowledged the preemptive effect of its implementing regulation. The new rules, which become applicable at the earliest on January 1, 2002, specifically exclude certain state laws regulating insurance from the preemptive scope of the regulation. 29 C.F.R. § 2560.503-1(k) (effective Jan. 20, 2001); 65 Fed. Reg. 70,246, 70,254 (Nov. 21, 2000) (explaining subsection (k)); PWBA Press Release 01-31 (July 6, 2001) (extending date for group health plans to comply with new claims procedure rules), *available at* http://www.dol.gov/dol/pwba/public/media/press/pr070601.htm. Respondent's state law claims plainly are not laws regulating insurance within the meaning of the saving clause, ERISA § 514(b)(2)(A); *see, e.g., Pilot Life*, 481 U.S. at 48-52—nor would the saving clause apply to a self-funded plan such as the one at issue in this case. *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990).

administration would be thwarted if third-party administrators like Petitioner could be required to comply with standards imposed by state law in processing benefit claims. *Fort Halifax*, 482 U.S. at 9. As this Court stated recently, "[r]equiring ERISA administrators to master the relevant laws of the 50 States and to contend with litigation would undermine the congressional goal of 'minimiz[ing] the administrative and financial burden[s]' on plan administrators—burdens ultimately borne by the beneficiaries." *Egelhoff*, 121 S. Ct. at 1329 (quoting *Ingersoll-Rand Co.*, 498 U.S. at 142).

II. ALLOWING SPONSORS TO ASSERT STATE LAW CLAIMS FOR IMPROPER CLAIMS PROCESSING WOULD INHIBIT RESPONSIBLE DECISION-MAKING, INCREASE EMPLOYEE BENEFIT PLAN COSTS, AND DETER QUALIFIED PERSONS FROM PROVIDING ADMINISTRATIVE SERVICES TO PLANS

This Court has ruled that extracontractual damages cannot be awarded to participants under ERISA § 502(a)(2) based upon an administrator's improper processing of a claim for benefits. *Russell*, 473 U.S. at 148; 29 U.S.C. § 1132(a)(2).[17] The Court also has ruled that ERISA § 502(a)(3) authorizes only equitable relief, *not* money damages. *Mertens v.*

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[17] Having reviewed the statutory text and regulations relating to claims procedures, the Court in *Russell* found "nothing" to support a conclusion that delayed processing of claims gives rise to a cause of action for compensatory or punitive damages under ERISA. *Russell*, 473 U.S. at 144. Indeed, under the Department's regulation, the consequence at the initial processing stage of failing to notify a claimant of a denial within a reasonable time is that the claim is deemed denied, permitting the claimant to proceed to the "review stage." 29 C.F.R. § 2560.503-1(e)(2). Likewise, as the Court noted in *Russell*, the consequence of failing to furnish a claimant with a review decision promptly is that the claim is deemed denied on review. 29 C.F.R. § 2560.503-1(h)(4); *Russell*, 473 U.S. at 144.

Hewitt Assocs., 508 U.S. 248, 256-58 (1993); 29 U.S.C. § 1132(a)(3). In addition, emphasizing the "clear expression of congressional intent that ERISA's civil enforcement scheme be exclusive," the Court has ruled that ERISA preempts a participant's state common law causes of action alleging improper processing of a claim for benefits. *Pilot Life*, 481 U.S. at 57.

Viewed in this context, the Eleventh Circuit's decision affirming an award of damages *to the sponsoring employer* under state law can only encourage administrators to place the interests of the employer above those of the plan and its participants when processing claims. The interests of the employer, of course, are likely to diverge from those of the plan and the participants whose claims are being processed, particularly in situations where the employer is ultimately responsible for funding the payment of benefits. Encouraging administrators like Petitioner to act in the interest of the employer would be contrary to one of ERISA's central purposes—to "insulate the trust from the employer's interest." *NLRB v. Amax Coal Co.*, 453 U.S. 322, 333 (1981). Furthermore, since administrators would face potential liability for any alleged harm suffered by the plan sponsor due to delays in processing participants' claims, such damage awards would encourage administrators to place a premium upon speed at the expense of the thorough, deliberate consideration of benefit claims contemplated by ERISA.

The allowance of punitive damages under state law only compounds the disruptive impact of the Eleventh Circuit's decision. Such awards, of course, serve no compensatory purpose, but represent mere windfalls to prevailing plaintiffs. *See Smith v. Wade*, 461 U.S. 30, 59 (1983) (Rehnquist, J., dissenting); *City of Newport v. Fact Concerts, Inc.*, 453 U.S. 247, 266 (1981); *Int'l Bhd. of Elec. Workers v. Foust*, 442 U.S. 42, 50 (1979). At the same time, such awards have rested on standards that are both ill-defined and unevenly

applied. *See TXO Prod. Corp. v. Alliance Resources Corp.*, 509 U.S. 443, 472-75 (1993) (O'Connor, J., dissenting); *Browning-Ferris Indus. v. Kelco Disposal, Inc.*, 492 U.S. 257, 281 (1989) (Brennan, J., concurring); *Smith*, 461 U.S. at 60 (Rehnquist, J., dissenting).

Lacking a consistent framework of analysis, courts have developed a variety of ad hoc tests to determine both the entitlement to, and the measure of, punitive relief. *See, e.g., BMW of N. Am., Inc. v. Gore*, 517 U.S. 559, 588-89 (1996) (Breyer, J., concurring); *Pac. Mut. Life Ins. Co. v. Haslip*, 499 U.S. 1, 42-43 (1991) (O'Connor, J., dissenting); *Smith*, 461 U.S. at 60-64 (Rehnquist, J., dissenting). The arbitrary nature of these standards often fails to provide defendants with fair warning of the consequences of their actions, thus negating the primary purpose of punitive damage awards—deterrence of conduct which violates legal standards. *See, e.g., Gore*, 517 U.S. at 574-75; *Smith*, 461 U.S. at 59 (Rehnquist, J., dissenting).

The detrimental impact of this state of affairs on employee benefit plans is self-evident. Without a uniform federal standard, punitive damages are likely to fall unevenly upon those responsible for claims processing, depending upon the state in which they are sued. *See Cooper Indus. v. Leatherman Tool Group, Inc.*, 121 S. Ct. 1678, 1683 n.6 (2001); *Gore*, 517 U.S. at 613 n.6, 614-19 (Ginsburg, J., dissenting); *Smith*, 461 U.S. at 59-64 (Rehnquist, J., dissenting). Moreover, the broad discretion accorded to the trier of fact to set the amount of punitive damages must inevitably lead to inconsistent results, *see TXO*, 509 U.S. at 473-75 (O'Connor, J., dissenting), which cannot be squared with Congress's emphasis in ERISA on predictability and uniformity.[18] *See Int'l Bhd. of Elec. Workers*, 442 U.S. at 50-52.

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[18] H.R. Rep. No. 93-533, *supra* note 3, at 12, *reprinted in* 1974 U.S.C.C.A.N. at 4650 ("The uniformity of decision which the Act is

Subjecting administrators like Petitioner to punitive damages would unsettle the delicate balance of costs and protections reflected in ERISA. The prospect of substantial, unpredictable punitive damage awards would increase the cost of providing administrative services to employee benefit plans. These costs inevitably would be passed back to the plans in the form of increased fees, to the ultimate detriment of the plans' participants and beneficiaries. *See Mertens*, 508 U.S. at 262 (exposing non-fiduciary service providers to liability for consequential damages would "impose high insurance costs upon persons who regularly deal with and offer advice to ERISA plans, and hence upon ERISA plans themselves."). Because of the difficulty of obtaining insurance coverage for punitive damages, many qualified persons would be deterred from providing administrative services to employee benefit plans. *See Browning-Ferris*, 492 U.S. at 282 (O'Conner, J., dissenting). These predictable results would frustrate Congress's goal of minimizing the costs and burdens imposed on employee benefit plans in order to promote their growth. *See Mertens*, 508 U.S. at 262-63; H.R. Rep. No. 533, *supra* note 3, at 1, *reprinted in* 1974 U.S.C.C.A.N. at 4639-40 (projected cost of each provision of ERISA analyzed in relation to anticipated benefit).

III. THIS COURT'S GUIDANCE IS NEEDED TO RESOLVE CONFUSION OVER THE APPLICATION OF ERISA PREEMPTION TO STATE LAW CLAIMS AGAINST THIRD-PARTY ADMINISTRATORS

The Eleventh Circuit's decision in this case conflicts with *Pilot Life* and with the Fourth Circuit's decision in *Tri-State Machine*. This Court ruled in *Pilot Life* that state common

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designed to foster will help administrators, fiduciaries and participants to predict the legality of proposed actions without the necessity of reference to varying state laws.").

law causes of action alleging improper processing of a claim for benefits "undoubtedly" met the criteria for ERISA preemption. *Pilot Life*, 481 U.S. at 57. Relying on *Pilot Life*, the Fourth Circuit held in *Tri-State Machine* that ERISA preempted a plan sponsor's state law claims against a third-party administrator under circumstances similar to those presented here. As in this case, the sponsor alleged that a third-party administrator of its self-funded plan delayed processing benefit claims to avoid coverage under a stop-loss insurance policy issued by the administrator. *Tri-State Machine,* 33 F.3d at 314. In holding that ERISA preempted the sponsor's state law claims, the Fourth Circuit reasoned that the state claims were "essentially complaints about the processing of claims under an employee benefit plan and, therefore, *relate to* the plan in the common sense meaning of that phrase." *Id.*

Resolution of this conflict is of critical importance to third-party administrators of self-funded employee benefit plans. In a self-funded plan, the employer (or trust in the case of a multiemployer plan) pays the benefit claims of plan participants out of its own assets. *See FMC Corp.*, 498 U.S. at 61-62 (distinguishing between insured and self-funded plans). A recent study estimated that 47.9 million individuals (39% of those in private sector, employment-based health plans) were enrolled in self-funded private sector, employment-based health plans in 1997. Employee Benefits Research Institute, *Employment-Based Health Care Benefits and Self-Funded Employment-Based Plans: An Overview* at 6 (Apr. 2000).[19] These self-funded plans typically are administered by a third-party administrator, which may be an insurance company or other independent organization that specializes in the provision of administrative services to plans. *See* Employee Benefits Research Institute, *Issue Brief No. 193*, at 18 (Jan. 1998).

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[19] *Available at* http://www.ebri.org/facts/0400fact.pdf.

Absent review by this Court, the Eleventh Circuit's decision can only exacerbate existing uncertainty about the application of ERISA's preemption provision to state law claims against third-party administrators. Preemption cases involving state law claims against third-party administrators are recurrent, and the case law reflects considerable confusion about the circumstances under which such claims may be preempted by ERISA. *See Geweke Ford v. St. Joseph's Omni Preferred Care Inc.*, 130 F.3d 1355, 1359-60 (9th Cir. 1997) (ERISA did not preempt plan sponsor's state law breach of contract claim against third-party administrator); *Coyne & Delany Co. v. Selman*, 98 F.3d 1457, 1471-72 (4th Cir. 1996) (ERISA did not preempt sponsor's state law professional malpractice claim against third-party administrator); *Tri-State Machine*, 33 F.3d at 313-14 (ERISA preempted plan sponsor's state law claims against third-party administrator); *Kyle Rys. v. Pac. Admin. Servs.*, 990 F.2d 513, 518-19 (9th Cir. 1993) (ERISA preemption of sponsor's state law claims against third-party administrator does not violate due process clause).[20] A decision by this Court would provide much

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[20] *See also Hughes Supply, Inc. v. Robey-Barber Ins. Servs.*, No. 99-2904-Civ-T-17C, 2000 WL 782954, at **5-7 (M.D. Fla. June 5, 2000) (ERISA preempted sponsor's state law action for conversion and breach of contract against third-party administrator); *Analytical Surveys, Inc. v. Intercare Health Plans, Inc.*, 101 F. Supp. 2d 727, 734-36 (S.D. Ind. 2000) (ERISA did not preempt sponsor's state law breach of contract and gross negligence claims against third-party administrator for delayed processing of benefit claims); *Tie Communications, Inc. v. First Health Strategies, Inc.*, No. Civ-A-97-2597-EEO, 1998 WL 171126, at **2-5 (D. Kan. Mar. 3, 1998) (ERISA did not preempt sponsor's state law breach of contract claim against third-party administrator for failure to provide stop-loss insurer with information about a participant's claim in a timely manner); *Hartford Fire Ins. Co. v. E.A. Sween Co.*, 920 F. Supp. 1021, 1028-29 (D. Minn. 1996) (ERISA preempted sponsor's state law breach of contract, negligence and bad faith claims against third-party administrator); *Union Health Care, Inc. v. John Alden Life Ins. Co.*, 908 F. Supp. 429, 435-36 (S.D. Miss. 1995) (ERISA did not preempt sponsor's state law claim against third-party administrator for failure to

needed clarity and guidance as to the duties and liabilities of third-party administrators under state and federal law in providing administrative services to self-funded plans.

IV. THE ELEVENTH CIRCUIT'S DECISION UNDERMINES CONGRESS'S INTENT TO PROVIDE UNIFORM STANDARDS OF FIDUCIARY CONDUCT AND EXCLUSIVE REMEDIES FOR FIDUCIARY BREACHES

Review of the Eleventh Circuit's decision is necessary to restore the primacy of federal regulation in the critical area of fiduciary standards. In enacting ERISA, Congress sought to establish a uniform federal regulatory scheme for evaluating fiduciary conduct. H.R. Rep. No. 93-533, *supra* note 3, at 12, *reprinted in* 1974 U.S.C.C.A.N. at 4650 ("[A] fiduciary standard embodied in Federal legislation is considered desirable because it will bring a measure of uniformity in an area where decisions under the same set of facts may differ from state to state.").[21] Congress accomplished this goal by formulating detailed federal standards to guide fiduciaries,[22] and by specifying the remedies available for enforcement of these fiduciary responsibility requirements. *See Varity Corp. v. Howe*, 516 U.S. 489, 507-09 (1996).

As this Court observed in *Varity*, an administrator is a fiduciary under ERISA to the extent it makes discretionary decisions about whether participants are entitled to benefits under a plan's terms. *Varity*, 516 U.S. at 511; ERISA

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notify stop-loss carrier in a timely manner); *Fox, Curtis & Assocs. v. Employee Benefit Plans, Inc.*, No. 92-C-5828, 1993 WL 265474, at **3-6 (N.D. Ill. July 13, 1993) (ERISA did not preempt sponsor's state law breach of contract and Illinois Consumer Fraud and Deceptive Practices Act claims against third-party administrator).

[21] *See also* 120 Cong. Rec. 29,933 (1974) (remarks of Sen. Williams); *id.* at 29,197 (remarks of Rep. Dent).

[22] See ERISA §§ 401-14, 29 U.S.C. §§ 1101-14.

§ 3(21)(A)(iii), 29 U.S.C. § 1002(21)(A)(iii).[23] Under the SPD's written terms, Petitioner was an ERISA fiduciary because it was the entity responsible for reviewing denied claims.[24] Indeed, ERISA provides expressly that a participant must be afforded a reasonable opportunity for such review by an "appropriate named *fiduciary*." ERISA § 503(2), 29 U.S.C. § 1133(2) (emphasis added). According to the Department of Labor, a person is a fiduciary to the extent such person has "final authority to authorize or disallow benefit payments in cases where a dispute exists as to the interpretation of plan provisions relating to eligibility for benefits." 29 C.F.R. § 2509.75-8, Q-D-3. And the Department has made clear that a person who reviews denied claims under ERISA § 503(2) "must [have] authority to make a final decision on the claim." 42 Fed. Reg. 27,426, 27,426 (May 27, 1977) (preamble to 29 C.F.R. § 2560.503-1).[25]

Respondent's state law breach of fiduciary duty and "wantonness" claims accused Petitioner of intentionally delaying the processing of claims for its own financial benefit—conduct which amounts to ERISA disloyalty, conflict of interest, and self-dealing violations. As an ERISA fiduciary, Petitioner had a duty under ERISA § 404(a)(1)(A) to act "solely in the interest" of the plan's participants and

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[23] *Cf. Pegram v. Herdrich*, 530 U.S. 211, 228-37 (2000) (HMO physicians' "mixed" eligibility and treatment decisions are not fiduciary decisions under ERISA).

[24] *See, e.g., Reich v. Lancaster*, 55 F.3d 1034, 1047 (5th Cir. 1995) (third-party administrator may be an ERISA fiduciary if it has the authority to "grant, deny, *or review denied claims*") (emphasis added).

[25] That the SPD did not describe any procedure for appealing a denied claim to Respondent demonstrates that a decision by Petitioner on review was final for purposes of exhausting all remedies available under the plan. *See, e.g., Russell*, 473 U.S. at 144 (consequence of deeming a claim denied on review is that the claimant can "bring a civil action to have the merits of his application determined, just as he may bring an action to challenge an outright denial of benefits").

beneficiaries and for the "exclusive purpose" of providing benefits and defraying reasonable expenses of administration.[26] *See Pegram*, 530 U.S. at 223-25. Petitioner also was subject to the prohibited transaction provisions of ERISA § 406(b), which proscribe fiduciary conflicts of interest and self-dealing.[27] *See Lockheed Corp. v. Spink*, 517 U.S. 882, 888 (1996); *Russell*, 473 U.S. at 143 n.10.

ERISA's civil enforcement scheme provides a host of remedies for these alleged fiduciary violations.[28] For example, the remedies available under ERISA § 409(a) include restoration of all losses resulting to the plan,[29] restitution of ill-gotten profits,[30] and "other equitable or

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[26] 29 U.S.C. § 1104(a)(1)(A).

[27] The prohibitions of ERISA § 406(b), 29 U.S.C. § 1106(b), are designed to deter fiduciaries "from exercising the authority, control, or responsibility which makes [them] fiduciaries when they have interests which conflict with the interests of the plans for which they act." 29 C.F.R. § 2550.408b-2(e)(1).

[28] As noted earlier, in opposing Petitioner's summary judgment motion, Respondent acknowledged that it could pursue such remedies against Petitioner. *See supra* at 5.

[29] *See, e.g., Libbey-Owens-Ford Co. v. Blue Cross & Blue Shield Mut.*, 982 F.2d 1031, 1034-39 (6th Cir.) (complaint against third-party administrator stated ERISA claim for an accounting and restitution of improperly paid nursing-home claims), *cert. denied*, 510 U.S. 819 (1993); *cf. Harold Ives Trucking Co. v. Spradley & Coker, Inc.*, 178 F.3d 523 (8th Cir. 1999) (third-party administrator liable under ERISA § 409 for breach of fiduciary duty in failing to notify plan administrator that stop-loss insurer had denied coverage of claim).

[30] *See, e.g., Am. Fed'n of Unions Local 102 Health & Welfare Fund v. Equitable Life Assurance Soc'y*, 841 F.2d 658, 662-64 (5th Cir. 1988) (third-party administrator liable under ERISA § 409 for benefits paid to ineligible claimants and for commissions earned on improper benefit payments); *The Sixty-Five Sec. Plan v. Blue Cross & Blue Shield*, 583 F. Supp. 380, 388 (S.D.N.Y. 1984) (ERISA complaint stated fiduciary conflict of interest claim against third-party administrator for allegedly overpaying claims to increase its fees).

remedial relief as the court may deem appropriate," including removal of the fiduciary.[31] *See Mertens*, 508 U.S. at 252-53. Appropriate equitable relief also is available under ERISA § 502(a)(3). 29 U.S.C. § 1132(a)(3); *see Harris Trust & Sav. Bank v. Salomon Smith Barney, Inc.*, 530 U.S. 238, 250-53 (2000). And in such actions, a court in its discretion may allow an award of attorney's fees and costs to either party under ERISA § 502(g).[32] 29 U.S.C. § 1132(g); *see Pilot Life*, 481 U.S. at 53.

Unless reversed, the Eleventh Circuit's decision will undermine this comprehensive regulatory framework and the important principles of uniformity on which it is based. *See Ingersoll-Rand Co.*, 408 U.S. at 145 (ERISA preempts state law cause of action purporting to provide alternate enforcement mechanism for breach of an ERISA obligation). Respondent's state law claims not only attempt to regulate the conduct of an ERISA fiduciary, but also are in direct conflict with ERISA's fiduciary responsibility requirements. In particular, Respondent's claims of breach of fiduciary duty and "wantonness" purport to require Petitioner to carry out its administrative functions in compliance with state law duties of care and loyalty owed to Respondent in its capacity as *employer*. These state law duties plainly conflict with ERISA's duty of loyalty, which requires Petitioner to act with "'an eye single' toward [the plan] beneficiaries' interests." *Pegram*, 530 U.S. at 235 (quoting *Donovan v. Bierwirth*, 680

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[31] *See Russell*, 473 U.S. at 147 ("If the plan administrator's refusal to pay contractually authorized benefits had been willful and part of a larger systematic breach of fiduciary obligations, [the plan participant] . . . could have asked for removal of the fiduciary pursuant to §§ 502(a)(2) and 409.").

[32] Additionally, the Secretary of Labor may assess a civil penalty against a breaching fiduciary under ERISA § 502(l).[32] 29 U.S.C. § 1132(l); *see Harris Trust & Sav. Bank.*, 530 U.S. at 248; *Mertens*, 508 U.S. at 259-61.

F.2d 263, 271 (2d Cir. 1982)). By affirming a judgment against Petitioner for allegedly breaching these purported state law duties owed to Respondent, the Eleventh Circuit's decision can only frustrate Congress's intent to establish a uniform federal law for evaluating fiduciary conduct. *See Fort Halifax*, 482 U.S. at 11.

V. THE QUESTIONS PRESENTED BY THIS PETITION HOLD IMPORTANT IMPLICATIONS FOR THE INTEGRITY OF THE CLAIMS PROCESSING FUNCTION PERFORMED ON BEHALF OF EMPLOYEE BENEFIT PLANS

The Department of Labor has estimated that there are now more than 6 million private employee benefit plans covering approximately 150 million people and controlling more than $5 trillion in assets. U.S. Dep't of Labor, Pension & Welfare Benefits Administration, *Annual Performance Plan—Fiscal Year 2002*.[33] More than 2.5 million of these plans are group health plans providing coverage to more than 125 million participants and making benefit-related expenditures in excess of $250 billion annually. *Id.* Many of these plans, moreover, are multi-state in operation.

Claims processors for employee benefit plans can be expected to process literally millions of claims for disability, pension and health benefits annually. Although the review of denied claims under a plan's ERISA-mandated claims procedure is necessarily a fiduciary function within the meaning of ERISA § 3(21)(A)(iii),[34] the Department of Labor has expressed the view that the initial "[p]rocessing of

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[33] *Available at* http://www.dol.gov/dol/pwba (accessed via library link).

[34] 29 U.S.C. § 1002(21)(A)(iii).

claims" may be a ministerial, non-fiduciary function.[35] Frequently, those who perform this initial "claims processing" function are either employees or agents of the person who serves as the plan's claims review fiduciary under ERISA § 503(2).

Because these persons are fiduciaries only "to the extent" that they perform one of the functions listed in ERISA § 3(21)(A)(iii), *see Pegram*, 530 U.S. at 225-26, the Eleventh Circuit's decision creates confusion as to whether such persons may be liable to plans or plan sponsors under state law for improper processing of claims. *Cf. Mertens*, 508 U.S. at 261 (assuming without deciding that ERISA preempts state law claims against non-fiduciaries for knowing participation in a fiduciary breach); *id.* at 267 n.2 (White, J., dissenting). A decision by the Court is necessary to provide guidance to these persons as to their respective duties and liabilities under state and federal law in the performance of this initial "claims processing" function. This Court's intervention is critical to restore the carefully crafted balance between state and federal law struck by Congress in ERISA and to reestablish the preeminence of ERISA's civil enforcement scheme in a core area of plan administration.

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[35] *See* 29 C.F.R. § 2509.75-8, Q-D-2 and Q-D-3.

CONCLUSION

For the reasons stated above, this Court should grant AMS's petition for a writ of certiorari and reverse the decision of the United States Court of Appeals for the Eleventh Circuit.

Respectfully submitted,

PAUL J. ONDRASIK, JR.
Counsel of Record
ERIC G. SERRON
STEPTOE & JOHNSON LLP
1330 Connecticut Avenue, N.W.
Washington, D.C. 20036
(202) 429-3000
Attorneys for Petitioner

August 2, 2001

APPENDIX A

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

[Filed May 04, 2001]

No. 00-14034-JJ

SKILSTAF, INC.,
Plaintiff-Appellee,

versus

AMERICAN MEDICAL SECURITY, INC.,
Defendant-Appellant.

On Appeal from the United States District Court for the
Middle District of Alabama

ON PETITION(S), FOR REHEARING AND PETITION(S) FOR REHEARING EN BANC

(Opinion _____, 11th Cir., 19___, F.2d ___).

Before: WILSON and COX, Circuit Judges and RYSKAMP* District Judge.

PER CURIAM:

The Petition(s) for Rehearing are DENIED and no member of this panel nor other Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate Procedure; Eleventh Circuit Rule 35-5); the Petition(s) for Rehearing En Banc are DENIED.

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* Honorable Kenneth L. Ryskamp, U.S. District Judge for the Southern District of Florida, sitting by designation.

ENTERED FOR THE COURT:

/s/ Illegible
UNITED STATES CIRCUIT JUDGE

ORD-42 (6/95)

APPENDIX B

[DO NOT PUBLISH]

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

[Filed Mar. 9, 2001]

No. 00-14034

D. C. Docket No. 98-00064-CV-M-E

SKILSTAF, INC.,
Plaintiff-Appellee,
versus
AMERICAN MEDICAL SECURITY, INC.,
Defendant-Appellant.

Appeal from the United States District Court
for the Middle District of Alabama

(March 9, 2001)

Before WILSON and COX, Circuit Judges. and Ryskamp*, District Judge.

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* Honorable Kenneth L. Ryskamp, U. S. District Judge for the Southern District of Florida, sitting by designation.

PER CURLAM:

AFFIRMED. See 11th Cir. R. 36-1.**

** 11th Cir. R. 36-1 provides:

When the court determines that any of the following circumstances exist:

(a) judgment of the district court is based on findings of fact that are not clearly erroneous;

(b) the evidence in support of a jury verdict is sufficient;

(c) the order of an administrative agency is supported by substantial evidence on the record as a whole;

(d) summary judgment, directed verdict, or judgment on the pleadings is supported by the record;

(e) judgment has been entered without a reversible error of law; and an opinion would have no precedential value, the judgment or order may be affirmed or enforced without opinion.

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
EASTERN DIVISION

[Filed Jun. 30, 2000]

Civil Action No. 98-M-64-E

SKILSTAF, INC.,

Plaintiff,

v.

AMERICAN MEDICAL SECURITY, INC., and
UNITED WISCONSIN LIFE INSURANCE COMPANY,

Defendants.

ORDER

Following a trial by jury which concluded on 27 August 1999, the court entered an order, judgment and decree on 31 August 1999 against the defendants on the plaintiff's claims of breach of contract, negligence, breach of fiduciary duty, and wantonness. The jury awarded the plaintiff the sum of $6,902,576.00 which included punitive damages. During the trial, the court denied the defendants' motions for directed verdict at the close of the plaintiff's case and at the end of the trial.

On 14 September 1999, defendant filed a motion for Judgment Notwithstanding the Verdict, Motion for New Trial, and a Motion for Remittitur (Doc. # 164), to which the plaintiff responded on on 1 October 1999 (Doc. # 170). After several extensions for filing responses and briefs, on 20 March 2000, the court entered an order granting in part and denying in part the Motion for Judgment Notwithstanding the Verdict, the Motion for New Trial, and the Motion

Remittitur; and granting the defendant's request for oral argument on the award of punitive damages. Oral argument was conducted on 2 May 2000. In the meantime, however, the defendant filed its Notice of Appeal on 18 April 2000, and the appellate process was begun, including the filing of the transcript order and other submissions.

Thereafter, an issue arose with respect to the finality of this court's disposition, and derivatively, the ripeness of the appeal. The defendant has now dismissed its appeal. The court has considered the motions pending before it and the parties' oral and written requests for clarification and finds that there is need for clarification. First, the court finds that the order entered on 20 March 2000 which granted in part and denied in part the defendant's post-trial motion was not a final order, inasmuch as a hearing on the remaining issue was yet to be held. Second, this court retained jurisdiction to consider the issue of punitive damages after oral argument. Third, defendant's filing of a Notice of Appeal on 18 April 2000 was premature.

Having held the hearing, however, and considered the issues presented, it is hereby

ORDERED that the defendant's motion for remittitur is hereby DENIED, and that the defendant's Motion for Judgment Notwithstanding the Verdict, Motion for New Trial, and a Motion for Remittitur are DENIED in their entirety. The court considers this order to be a final order from which an appeal lies.

DONE this 30th day of June, 2000

/s/ Vanzetta Penn McPherson
VANZETTA PENN MCPHERSON
UNITED STATES MAGISTRATE JUDGE

APPENDIX D

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
EASTERN DIVISION

[Filed Mar. 20, 2000]

Civil Action No. 98-M-64-E

SKILSTAF, INC.,

Plaintiff,

v.

AMERICAN MEDICAL SECURITY, INC.,

Defendant.

ORDER

On 22 January 1998, the plaintiff, Skilstaf, Inc., filed this action against American Medical Security, Inc., ["AMS"] (Doc. # 1). Following the trial in June 1999, the jury returned a verdict against AMS and awarded the following amounts:

1. $ 30,000.00 for breach of contract
2. $450,000.00 on the negligence claim
3. $1,422,576.00 for breach of fiduciary duty
4. $5,000,000.00 on the wantonness claim

(Doc. # 161). This case is now before the court on AMS' Motion for Judgment Notwithstanding the Verdict[1]

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[1] The plaintiff correctly noted that the drafters of the Federal Rules of Civil Procedure have replaced the term JNOV with "Judgment as a Matter of Law". (Doc. # 170, p. 3, n.1). See Fed. R. Civ. Pro. 50. "For simplicity's sake, however," the plaintiff used the disfavored term JNOV throughout its opposition (Doc. # 170, p. 3, n. 1). Similarly, the court will use the term JNOV because the parties have used it in their briefs.

["JNOV"], Motion for New Trial and/or Remittitur (Doc. #164). For the reasons that follow, the court concludes that AMS' Motion should be DENIED in part and GRANTED in part.

I. STANDARD OF REVIEW

A. Judgment Notwithstanding the Verdict

The Court of Appeals has stated that in deciding a motion for JNOV:

> A district court may enter judgment as a matter of law if a party has been fully heard on an issue and there is no legally sufficient basis for a reasonable jury to find in favor of that party on that issue. When considering such a motion, the court must evaluate all of the evidence, together with any logical inferences therefrom, in the light most favorable to the nonmoving party.

Carter v. DecisionOne Corp. Through C. T. Corp. System, 122 F.3d 997, 1003 (11th Cir. 1997) (citing *Beckwith v. City of Daytona Beach Shores*, 58 F.3d 1554, 1560 (11th Cir.1995)). The Court of Appeals has stated that:

> [i]f the facts and inferences point overwhelmingly in favor of one party, such that reasonable people could not arrive at a contrary verdict, then the motion was properly granted. Conversely, if there is substantial evidence opposed to the motion such that reasonable people, in the exercise of impartial judgment, might reach differing conclusions, then such a motion was due to be denied and the case was properly submitted to the jury.

Id. A Judgment NOV is appropriate when, "[r]esolving all the factual disputes and drawing all logical inferences in favor of the nonmoving party, [the court] determine[s] whether these facts and inferences so strongly favor one party "that reasonable people, in the exercise of impartial judgment, could not arrive at a contrary verdict.'" *Rankin v. Evans*, 133

F.3d 1425, 1435 (11th Cir.), *cert. denied*,___U.S.___, 119 S.Ct. 67 (1998) (citing *Bailey v. Board of County Comm'rs of Alachua County*, 956 F.2d 1112, 1119 (11th Cir.), *cert. denied*, 506 U.S. 832 (1992)). However, "a 'mere scintilla of evidence does not create a jury question; there must be a substantial conflict in evidence to create a jury question.'" *Id.* (citations omitted).

A motion for a judgment as a matter of law "may be used to renew consideration of issues initially raised in a pre-verdict motion for judgment as a matter of law." *Caban-Wheeler v. Elsea*, 71 F.3d 837, 842 (11th Cir. 1996) (citing Fed. R. Civ. Pro. 50(b)). In other words, a renewed motion for judgment as matter of law may be used to renew consideration of issues initially raised in pre-verdict for judgment as matter of law. Moreover, an issue that was not raised during trial or at any time before, is waived. *Id.* (citing *FDIC v. Verex Assurance, Inc.*, 3 F.3d 391, 395 (11th Cir. 1993); *Narey v Dean*, 32 F.3d 1521, 1526 (11th Cir.1994)).

B. New Trial

Federal Rule of Civil Procedure 59(a) permits a court to grant a new trial "on all or part of the issues." The standard governing the grant of new trials is: "[w]here the practice permits a partial new trial, it may not properly be resorted to unless it clearly appears that the issue to be retried is so distinct and separable from the others that a trial of it alone may be had without injustice." *Overseas Private Inv. Corp. v Metropolitan Dade County*, 47 F.3d 1111, 1113 (11th Cir. 1995) (quoting *Gasoline Prods. v. Champlin Refining Co.*, 283 U.S. 494, 500 (1931)). The Court of Appeals has explained that:

> In reviewing whether the evidence suffices to support the verdict, we consider the evidence and all reasonable inferences in the light most favorable to the prevailing party. *Pearce v. Wichita Cty.*, 590 F.2d 128, 132-33 (5th

> Cir. 1979). A verdict may be overturned "only [i]f the facts and inferences point so strongly and overwhelmingly in favor of one party that . . . reasonable men could not arrive at a contrary verdict." *Id.* at 133 (citation omitted).

Id. "A motion for new trial may only be granted when the jury's verdict is against the great weight of the evidence." *Carter v. DecisionOne Corp.*, 122 F.3d at 1004 (citing *Simon v. Shearson Lehman Brothers, Inc.*, 895 F.2d 1304, 1310 (11th Cir.1990)). See also *Dudley v. Wal-Mart Stores, Inc.*, 166 F.3d 1317, 1320, n.3 (11th Cir. 1999). "Because 'a less stringent standard applies to a motion for a new trial than to a motion for judgment as a matter of law,' . . . failure to meet the former standard is fatal to the latter." *Dudley v. Wal-Mart Stores, Inc.*,166 F.3d at 13 20, n.3 (quoting *Holzapfel v. Town of Newburgh*, 950 F.Supp. 1261, 1272 (S.D.N.Y. 1997), *rev'd on other grounds*, 145 F.3d 516 (2nd Cir.1998)).

C. Alter or Amend Judgment

The Court of Appeals has further instructed that an argument made to the district count for first time in motion to alter or amend judgment would not be entertained on appeal. *Seamon v. Vaughan*, 921 F.2d 1217, 1220 (11th Cir. 1991) (affirming the district court's decision to refuse to hear arguments first raised in a motion brought pursuant to Rule 59 of the Federal Rules of Civil Procedure) (citing *American Home Assurance Co. v. Glenn Estess & Associates*, 763 F.2d 1237, 1238-39 (11th Cir. 1985)). Further, Rule 61 of the Federal Rules of Civil Procedure provides that:

> No error in either the admission or the exclusion of evidence and no error or defect in any ruling or order or in anything done or omitted by the court or by any of the parties is ground for granting a new trial or for setting aside a verdict or for vacating, modifying, or otherwise disturbing a judgment or order, unless refusal to take

such action appears to the court inconsistent with substantial justice. The court at every stage of the proceeding must disregard any error or defect in the proceeding which does not affect the substantial rights of the parties.

II. DISCUSSION

A. Preemption

AMS contends that the plaintiff's claims are preempted by the Employee Retirement Income Security Act ["ERISA"] (Doc. # 164, p. 2). The court rejects AMS' argument that it was a fiduciary of the plan because the jury could reasonably find from the evidence that AMS was merely a third-party administrator. That finding could have been based upon the plan-document which does not give AMS final authority on the payment of claims (Doc. # 162, Plaintiffs Trial Exhibit 1). In addition, although the plan-document may create obligations, the evidence indicated that the plaintiff's damages did not arise solely from the plan-document; rather, there were external failures by AMS. In other words, not all of the plaintiff's claims concern the timely processing and paying of insurance claims.[2] Accordingly, the court denies AMS' motion on this issue.

B. Provider Discounts

AMS contends that the plaintiff's claim for damages due to provider discounts was not supported by the evidence and should not have been submitted to the jury (Doc. # 164, p. 9). As to the various counts, the court charged the jury with several bases for finding AMS liable: (1) failing to disclose the amount of unpaid claims at the termination of the contract in May of 1996; (2) failing to use the knowledge, skill, expertise, and diligence required in connection with the

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[2] For examples, review the court's jury charge where it outlined other basis for finding AMS liable (Trial Transcript pp. 772-793).

plaintiff's insurance needs; (3) failing to process and pay claims in a timely manner which would have been covered by the excess loss policy prior to May of 1996; (4) failing to disclose the amount of unpaid claims at the time of termination; (5) failing to pay claims in a timely manner as to take advantage of provider discounts; and (6) taking improper provider discounts by untimely payments (Trial Transcript, pp. 781, 785).

After finding that the plaintiff proved by a preponderance of the evidence each element of each claim against AMS, the jury assessed differing damages for each claim (Doc. # 161). However, the jury's verdict does not indicate whether it based any of the damages on provider discounts (Doc. # 161). Further, AMS notes that the plaintiff did not request any monetary amounts for damages due to provider discounts (Doc. # 164, p. 10). The court rejects AMS' argument that the jury awarded the plaintiff damages on the basis of provider discounts because the jury could reasonably have premised its award of damages upon other reasons supported by the evidence. Moreover, AMS has failed to show that the allegations of provider discounts played any part in the jury's verdict.

C. Breach of Contract

1. Breach of Contract, Negligence, and Wantonness

AMS contends that the gravamen of the plaintiff's complaint is *ex contractu* (Doc. # 164, pp. 10, 12). Hence, AMS contends that the plaintiffs claims of negligence and wantonness should not have been submitted to the jury (Doc. # 164, p. 10).

The plaintiff's breach of contract claim was based on nonperformance, as expressed in the jury charge (Trial Transcript, p.780). In contrast, the negligence and wantonness claims were based on performance undertaken, but negligently so, as expressed in the jury charge (Trial Transcript,

pp. 781, 785). Consequently, the court rejects AMS' claim that the negligence and wantonness claims were based solely on the breach of contract and do not present independent torts.

2. Submission of Both Claims to the Jury[3]

In this motion, which was filed after the trial, AMS raises for the first time the contention that Alabama law does not support the existence of a cause of action for negligent and wanton handling of an insurance claim (Doc. # 164, p. 11). Although AMS was given an opportunity to object to the jury charge and took advantage of the opportunity, AMS failed to raise this argument (Trial Transcript, pp. 793-94). Because AMS did not object to the instructions at trial, the court reviews its argument solely for "plain error". *Bateman v. Mnemonics, Inc.*, 79 F.3d 1532, 1548 (11th Cir. 1996). According to a recent ruling of the Court of Appeals:

> Under the plain error doctrine, appellant's burden is an especially heavy one: In the absence of a proper objection to jury instructions, "we will reverse only in exceptional cases where the error is so fundamental as to result in a miscarriage of justice."

Pulliam v Tallapoosa County Jail, 185 F.3d 1183, 1188 (11th Cir. 1999) (citing *Iervolino v. Delta Airlines, Inc.*, 796 F.2d 1408, 1414 (11th Cir. 1986).

The court does not find that plain error occurred and therefore declines to grant AMS' motion on this issue. See *Andres v Roswell-Windsor Village Apartments*, 777 F.2d 670, 674 (11th Cir.1985) (declining "to reverse on alleged error not presented to the trial court").

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[3] Rule 51 of the Federal Rules of Civil Procedure provides that:

> No party may assign as error the giving or the failure to give an instruction unless that party objects thereto before the jury retires to consider its verdict, stating distinctly the matter objected to and the grounds of the objection.

D. Negligence and Wantonness

1. Lack of Evidence

AMS contends that the court erred in submitting the wantonness claim to the jury because there was a lack of evidence in support of the claim (Doc. # 164, p. 15). This claim must fail inasmuch as the jury could reasonably have found—and apparently did find—the existence of wantonness by clear and convincing evidence based on facts presented at the trial.

2. Verdicts for Both Negligence and Wantonness

AMS contends that the court erred in allowing the jury to return a verdict for both negligence and wantonness, based upon the same facts and/or allegations (Doc. # 164, p. 20). AMS contends for the first time in its post-trial motion for judgment as a matter of law that the jury could not return a verdict finding both negligence and wantonness. The court notes that during the jury charge conference or after the jury was charged, AMS did not object to the negligence and wantonness charges on the grounds that they are inconsistent (Trial Transcript, pp. 793-94). In fact, AMS requested jury charges on negligence and wantonness (Doc. # 157, Nos. 8-16). While requesting these jury charges, AMS failed to request a charge regarding this contention.

"Rightly or wrongly," the court instructed the jurors, without objection from AMS, "that they could render what might otherwise be inconsistent verdicts." *Shelby Ins. Co. v. Stocks*, 82 F.3d 1030,1032 (11th Cir. 1996). Because neither the plaintiff nor AMS' counsel "suggested to the judge that there was any error in this.[,] . . . . [i]t is too late now for . . . [AMS] to complain that the jury should not have been permitted to render such a Verdict. *Id.* Accordingly, the court denies AMS' motion on this issue.

E. The Verdict

1. Bias, Passion, or Prejudice

AMS contends that the jury's verdict was improper because it was based on bias, passion, or prejudice (Doc. # 164, p. 22). AMS comes to this conclusion because it contends that the record is void of any evidence that AMS acted with wantonness (Doc. # 164, p. 23). AMS fails to allude to or to identify any factors other than its notion of probability that would support a conclusion that the jury was biased or prejudiced against the defendants. Counsel for both sides conducted extended and pertinent voir dire of the jury, and counsel had an opportunity to observe the jurors throughout the trial. At no time during the trial was any suggestion made to the court that one or more jurors was engaged in anything but a reasonable and objective consideration of the evidence.

Having observed the jury throughout the trial, and having heard all of the witnesses' testimony, the court makes an independent finding that jury verdict was not based on bias, passion, or prejudice. Accordingly, the court denies this basis for granting AMS' motion. *United States v. Pedrick*, 181 F.3d 1264, 1272 (11th Cir. 1999) (stating that "[t]he district court saw the witnesses, heard all of the evidence, and is in the best position to evaluate whether Pedrick suffered compelling prejudice warranting a new trial").

2. Punitive Damages

AMS contends that the plaintiff's counsel's improper arguments are a basis for a new trial or remittitur (Doc. # 164, p. 24). Specifically, AMS contends that the following improper arguments provide a basis for a new trial: (1) plaintiff's counsel's reference to "boxes" of complaints against AMS notwithstanding AMS' objections; (2) Wynette Smith's ["Smith"], plaintiff's witness, reference to numerous complaints notwithstanding AMS' objections and the court's

admonition to her and plaintiff's counsel to refer only to complaints made by plaintiff's employees; and (3) Smith and plaintiff's counsel's comments to the jury that the Alabama Department of Insurance could not regulate AMS (Doc. # 164 p.24).

Aside from AMS' failure to cite specifically to the portions of the transcript where these allegedly improper arguments were made (Doc. # 164, p. 24), the court rejects AMS' argument because (1) as counsel states, the court ruled on objections at trial, (2) the references, even if technically objectionable, were not so substantial as to have changed the outcome of the trial, and (3) there are independent factual bases upon which a reasonable jury could have awarded punitive damages to the plaintiff.

a. New Trial

Not all errors made by "any of the parties is ground for granting a new trial or for setting aside a verdict or for vacating, modifying, or otherwise disturbing a judgment or order, unless refusal to take such action appears to the court inconsistent with substantial justice." *See Fed. R. Civ. P. 61.* "The standard for determining whether a jury verdict should be set aside as a result of misconduct of counsel is whether the conduct was 'such as to impair gravely the calm and dispassionate consideration of the case by the jury.'" *BankAltantic v. Blythe Eastman Paine Webber, Inc.*, 955 F.2d 1467, 1474 (11th Cir. 1992), *cert. denied*, 506 U.S. 1049 (1993) (citing *Allstate Insurance Co. v. James*, 845 F.2d 315, 318 (11th Cir. 1988)).

In this case, the "court saw the witnesses, heard all of the evidence, and is in the best position to evaluate whether . . . [AMS] suffered compelling prejudice warranting a new trial." *United States v. Pedrick*, 181 F.3d at 1272. Upon careful review of the statements challenged as prejudicial by AMS, the court finds that none of them constitute grounds for disturbing the judgment. *See Fed. R. Civ. P. 61.*

b. Remittitur [4]

The court may grant a remittitur "only where the record establishes that the award is excessive or inadequate as a matter of law, or where it is established and reflected in the record that the verdict is based upon bias, passion, corruption, or other improper motive. . ." *Hammond v City of Gadsden*, 493 So.2d 1374, 1379 (Ala. 1986).

AMS argues that the plaintiff's "[c]ounsel's improper arguments are a basis for a new trial or remittitur." (Doc. # 164, p. 24). AMS cited to several cases that allegedly stand for the preposition that the plaintiff's misleading arguments to the jury warrants remittitur (Doc. # 164, p. 24). In *Lance, Inc. v. Ramanauskas*, 731 So. 2d 1204, 1215-16 (Ala. 1999), the Supreme Court of Alabama found that the plaintiff's counsel made "improper argument as to the value of a particular life" during the opening statement and summation. The *Lance* Court "consider[ed] a remittitur to be the appropriate method of dealing with the improper arguments in this case." *Id.* In *Ridgeview Health Care Center, Inc. v. Meadows*, 590 So.2d 243, 245 (Ala. 1991), the Alabama Supreme Court found that the argument that a corporation has "no conscience" is an improper and highly prejudicial argument.

AMS has not provided a case in which a court found such arguments allegedly made by the plaintiff **in** the instant action to constitute an improper or prejudicial argument as to

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[4] "A remittitur is a substitution of the court's judgment for that of the jury regarding the appropriate award of damages." *Johansen v. Combustion Engineering, Inc.*, 170 F.3d 1320, 1331 (11th Cir.), *cert. denied sub nom.*, __ U.S. __, 120 S.Ct. 329 (1999). "The court orders a remittitur when it believes the jury's award is unreasonable on the facts." *Id.* "In evaluating whether a verdict is excessive, we must determine whether the verdict is so excessive as to 'shock the judicial conscience.'" *Riley v. Camp*, 130 F.3d 958, 979 (11th Cir.1997), *cert. denied*, __ U.S. __, 118 S.Ct. 2296 (1998) (citing *Woods v. Burlington Northern R.R. Co.*, 768 F.2d 1287, 1292 (11th Cir. 1985) (per curiam)).

warrant a remittitur (emphasis added). Upon careful review of the statements claimed prejudicial by AMS and a review of the cases cited by AMS, the court finds that none of them were "improper" or highly prejudicial as to warrant a remittitur.

Although AMS does not explicitly contend that the verdict was violative of its due process rights, AMS cites to the factors in determining the excessiveness of a punitive damages verdict as enumerated by the Alabama Supreme Court in ***Hammond v Gadsden***, 493 So. 2d 1374, 1379 (Ala. 1986), and ***Green Oil Co.*** *v. Hornsby*, 539 So. 2d 218, 223-24 (Ala. 1989) (Doc. # 164, p. 23) (citations omitted). The court finds that AMS' argument regarding the excessiveness of the verdict is not persuasive. For the sake of completeness, however, the court will consider this argument.

"Both the Alabama legislature and the Supreme Court of Alabama, in a manner approved by the Supreme Court of the United States, have mandated an independent review of an award of punitive damages which is attacked as excessive." *Enstar Group, Inc. v. Grassgreen*, 812 F. Supp. 1562, 1578 (M. D. Ala. 1993). In a diversity case and where otherwise appropriate, federal courts in Alabama should review a punitive damages award under the factors set forth in *Hammond v. Gadsden*, 493 So. 2d at 1379 and *Green Oil Co. v. Hornsby*, 539 So. 2d at 223-24. See *Pacific Mut. Life Ins. Co. v. Haslip*, 499 U.S. 1,2 (1991). See also *American Employers Ins. Co. v. Southern Seeding Services, Inc.*, 931 F.2d 1453, 1457 (11th Cir. 1991).

Factors to consider in determining the excess or inadequacy of a punitive damage award are: (1) the culpability of the defendant's conduct; (2) the desirability of discouraging others from similar conduct; (3) the impact on the parties; (4) the impact on innocent third parties; (5) whether the punitive damages bear a reasonable relationship to the harm that has occurred or is likely to occur; (6) the reprehensibility of the

defendant's conduct, the duration of the conduct, the defendant's awareness, any concealment, and the frequency of similar past conduct; (7) the profitability of the wrongful conduct to the defendant; (8) the financial position of the defendant; (9) the costs of litigation; (10) the imposition of criminal sanctions against the defendant; (11) and other civil awards against the defendant for the same conduct. *Id.*

Pursuant to Section 6-11-23(b) [5] of the Alabama Code, the court grants AMS' request for oral argument.

F. Breach of Fiduciary Duty

AMS contends that Alabama does not recognize breach of fiduciary duty as an independent tort (Doc. # 164, p. 25). The claim is without merit. The existence of such a claim is clear under Alabama Law. See *Green Tree Acceptance, Inc. v.*

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[5] Section 6-11-23(b) of the Alabama Code provides as follows:

> In all cases wherein a verdict for punitive damages is awarded, the trial court shall, upon motion of any party, either conduct hearings or receive additional evidence, or both, concerning the amount of punitive damages. Any relevant evidence, including but not limited to the economic impact of the verdict on the defendant or the plaintiff, the amount of compensatory damages awarded, whether or not the defendant has been guilty of the same or similar acts in the past, the nature and the extent of any effort the defendant made to remedy the wrong and the opportunity or lack of opportunity the plaintiff gave the defendant to remedy the wrong complained of shall be admissible; however, such information shall not be subject to discovery, unless otherwise discoverable, until after a verdict for punitive damages has been rendered. After such post verdict hearing the trial court shall independently (without any presumption that the award of punitive damages is correct) reassess the nature, extent, and economic impact of such an award of punitive damages, and reduce or increase the award if appropriate in light of all the evidence.

The Supreme Court of Alabama has held that portion of the statute which negates any presumption that the award of punitive damages is correct to be unconstitutional. *Armstrong v. Roger's Outdoor Sports, Inc.*, 581 So.2d 414 (Ala. 1991).

Tunstall, 645 So. 2d 1384, 1387 (Ala. 1994) (holding that "an action alleging breach of fiduciary duty could properly lie under" the facts alleged in that action). Further, the court finds that the evidence presented at trial was sufficient for the jury to find liability.

III. CONCLUSION

For the reasons articulated in this order, it is hereby ORDERED as follows:

1. The motion for Judgment Notwithstanding the Verdict, Motion for New Trial, and/or Remittiur filed by the defendant, American Medical Security, Inc. on 14 September 1999 (Doc. # 164) is GRANTED as to a request for oral arguments on the amount of the punitive damages award.

2. In all other respects, the motion is DENIED. Counsel for the parties are DIRECTED to appear for oral argument on the amount of punitive damages only on 26 April 2000 at 2:00 p.m. in Room 330, Frank M. Johnson, Jr. Federal Building and United States Courthouse, 15 Lee Street, Montgomery, Alabama.

3. In all other respects, the motion is DENIED.

The Clerk of the Court is DIRECTED to forward copies of this order to counsel of record via facsimile.

DONE this 20th day of March, 2000.

/s/ Vanzetta Penn McPherson
VANZETTA PENN MCPHERSON
UNITED STATES MAGISTRATE JUDGE

APPENDIX E

[Filed Aug 31, 1999]

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
EASTERN DIVISION

Civil Action No. 98-M-64-E

SKILSTAF, INC.,

Plaintiff,

v.

AMERICAN MEDICAL SECURITY, INC.,

Defendant.

JUDGMENT

On the 26th day of August 1999, after this cause had been submitted to a jury, a verdict was returned as follows:

1. We, the jury, find that Skilstaf, Inc. has proven by a preponderance of the evidence each element of its claim of breach of contract against the defendant American Medical Security, Inc., and assess damages for breach of contract in the amount of $ 30,000.00.

2. We, the jury, find that Skilstaf, Inc. has proven by a preponderance of the evidence each element of its claim of negligence against the defendant American Medical Security, Inc., and assess damages for negligence in the amount of $ 450,000.00.

3. We, the jury, find that Skilstaf, Inc. has proven by a preponderance of the evidence each element of its claim of breach of fiduciary duty against the defendant American Medical Security, Inc., and assess damages

for breach of fiduciary duty in the amount of $1,422,576.00.

4. We, the jury, find that Skilstaf, Inc. has proven by clear and convincing evidence each element of its wantonness claim against the defendant American Medical Security, Inc., and assess damages for wantonness in the amount of $5,000,000.00.

DONE this 26th day of August, 1999.

/s/ Wayne Goodman
WAYNE GOODMAN
FOREPERSON Signature

It is therefore the ORDER, JUDGMENT, and DECREE of the Court that the judgment is entered in favor of plaintiff Skilstaf, Inc. as to the breach of contract, negligence, breach of fiduciary duty, and wantonness claims, with plaintiff Skilstaf, Inc. recovering $ 6,902,576.00 as to the said claims.

DONE this 31st day of August, 1999.

/s/ Vanzetta Penn McPherson
VANZETTA PENN MCPHERSON
UNITED STATES MAGISTRATE JUDGE

APPENDIX F

[Filed Aug 20, 1999]

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
EASTERN DIVISION

Civil Action No. 98-M-64-E

SKILSTAF, INC.,

Plaintiff,

v.

AMERICAN MEDICAL SECURITY, INC.,
and UNITED WISCONSIN LIFE INSURANCE COMPANY,

Defendants.

ORDER

On 22 January 1998, the plaintiff, Skilstaf, Inc., filed this action against American Medical Security, Inc., ["AMS"] and United Wisconsin Life Insurance Company ["UWLIC"] (Doc. # 1). The plaintiff alleged the following causes of action against defendant AMS: (1) breach of contract, (2) negligence, (3) breach of fiduciary duty, (4) wantonness, and (5) fraud (Doc. # 32, pp. 10-15). The plaintiff's causes of action against UWLIC are (1) breach of contract, (2) bad faith, and (3) fraud (Doc. # 32, pp. 16-17). Jurisdiction is invoked pursuant to 28 U.S.C. § 1332 (West 1999).[1]

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[1] The plaintiff is an Alabama corporation with its principal place of business in Tallapoosa County, Alabama (Doc. # 32, ¶ 1). AMS is a corporation that was organized in a State other than the state of Alabama and has its principal place of business in the State of Wisconsin (Doc. # 32, ¶ 2; Doc. # 44, ¶ 2). UWLIC is a corporation that was organized in a State other than the state of Alabama and has its principal place of business in the State of Wisconsin (Doc. # 32, ¶ 3; Doc. # 44, ¶ 3). The amount in controversy in this case exceeds $75,000.00 (Doc. # 32, ¶ 5).

This case is now before the court on cross motions for summary judgment filed by the defendants on 10 May 1999 (Doc. # 66) and the plaintiff on 10 May 1999 (Doc. # 68). For the reasons that follow, the court concludes that the defendants' motion for summary judgment is GRANTED in part and DENIED in part.

I. FACTS

Pursuant to the Skilstaf, Inc. Flexible Benefit Plan ["Plan"], the plaintiff [2] provides certain of its employees with health benefits coverage (Doc. # 32, ¶7). Prior to its relationship with the defendants, the plaintiff provided its employees with health benefits coverage through Blue Cross and Blue Shield (Doc. # 69, Ex. 4, Stark Dep., p. 35). Blue Cross and Blue Shield informed the plaintiff that it could not provide health care benefits coverage to any more employees (Doc. # 69, Ex. 4, Stark Dep., p. 35).

Consequently, the plaintiff sought a third-party administrator and excess loss carrier (Doc. # 69, Ex. 3, Lamb Dep., pp. 113-114). Because the area of employer/ employee health benefits coverage is specialized and complex, the plaintiff relies on third-party administrators who specialize in that field to administer its health benefits plan (Doc. # 77, Ex. 23, Stark Dep., pp.143, 180-81). Pursuant to the plaintiff's request, AMS sent to the plaintiff a quote on the health insurance (Doc. # 69, Ex. 3, Lamb Dep., p. 56). The defendants allege that they gave the plaintiff its GroupMed Literature and Flex Funding Literature which explained that AMS and UWLIC were partners and that AMS's products were underwritten by UWLIC (Doc. # 67, p. 3; Doc. # 69, Exs.16, 17).

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[2] Stafco, Inc. ["Stafco"], an employee leasing company, established an "Employee Benefit Plan" to provide certain health care benefits for certain employees (Doc. # 32, ¶ 7). The plaintiff is a successor corporation to Stafco (Doc. # 32, ¶ 6).

In September 1992, the plaintiff selected AMS as its third-party administrator based on AMS's representations that it had superior knowledge and expertise as a third-party administrator in the health benefits field (Doc. # 77, Ex. 24, Lamb Dep., p. 50; Ex. 3, p. 7). The Administrative Services Agreement ["Agreement"] between AMS and the plaintiff establishes that AMS agreed to serve as the plaintiff's agent with respect to the health benefits plan [3] (Doc. # 77, Ex. 3, p. 2). According to the plaintiff, it considered AMS as its agent, consultant, expert, and advocate in administering its health benefits plan and in procuring excess loss insurance coverage for the partially self-insured plan (Doc. # 77, Ex. 23, Stark Dep., pp. 143, 180-81). Consequently, the plaintiff placed its trust and confidence in AMS to act in the plaintiff's best interest (Doc. # 77, Ex. 23, Stark Dep., pp. 143, 180-81).

AMS recommended that the plaintiff place its excess loss insurance coverage with UWLIC because it provided the broadest and fullest coverage available (Doc. # 69, Ex. 1, p. 2). Based upon AMS' agency relationship to it, the plaintiff accepted AMS' recommendation and purchased an "Excess Loss Insurance Policy" ["Policy"] from UWLIC (Doc. # 69, Exs. 1, 2).

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[3] The Agreement states in relevant part that the plaintiff "has requested AMS to be the Plan Supervisor of the Plan and act as its agent with regard to the payment of certain benefits of the Plan and to furnish certain services with respect to the Plan. . . ." (Doc. # 77, Ex. 3, p.1). The Agreement established that AMS has the responsibility for securing excess loss insurance coverage for the plaintiff (Doc. # 77, Ex. 3). The Agreement established that AMS was to act as the plaintiff's agent with respect to the Plan and to provide the plaintiff "with services and assistance in connection with the design and development of the Plan" (Doc. # 77, Ex. 3, p. 2). The Employer Group Application executed between the plaintiff and AMS reinforces AMS's responsibility (Doc. # 68, Ex. 2).

The Policy remained in effect from 1 September 1992 until 31 May 1996, when it was terminated by the plaintiff due to an alleged backlog in the processing of claims by AMS (Doc. # 69, Ex. 2, p. 00005; Ex. 6). One condition for the cancellation of coverage under the Policy is the cancellation of the Agreement between the plaintiff and AMS (Doc. # 69, Ex. 2, p. 00011). On 4 June 1996, the Plaintiff terminated the Agreement with AMS[4] (Doc. # 69, Ex. 6). The Policy provides that "UWLIC shall have no obligation to pay any Aggregate Excess Loss Insurance if this Policy terminates during the Policy Term" (Doc. # 69, Ex. 2, p. 00009).

When the agreements with the defendants were terminated, there existed a backlog of approximately one million dollars worth of claims that would have been reimbursed by the excess loss coverage (Doc. # 68, p. 6). According to the plaintiff, it would not have allowed its agreements with the defendants to be terminated had the plaintiff been aware of the backlog (Doc. # 68, p. 6).

The plaintiff subsequently paid the claims, and although the Plan's assets remain intact, the plaintiff alleges that it was damaged by the defendant's conduct (Doc. # 32, ¶36).

II. PROCEDURAL HISTORY

On 22 January 1998, the plaintiff filed his complaint in the instant case, alleging the following causes of actions against AMS: (1) breach of contract, (2) negligence, (3) breach of fiduciary duty, (4) wantonness, and (5) fraud (Doc. # 32, pp.10-11, 13-5). The plaintiff alleged the following causes of actions against *ULWIC*: (1) breach of contract, (2) bad faith, and (3) fraud (Doc. # 32, pp. 16-17).

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[4] Because the Policy term for the plaintiff was 1 September to 31 August, the plaintiff canceled the Policy midterm by terminating the Agreement on 4 June 1996 (Doc. # 6, Ex. 6).

In their brief in support of their motion for summary judgment, the defendants contend that the plaintiff cannot support its allegations against the defendants (Doc. # 67). The plaintiff denies the defendants' contentions in its response to the defendants' motion for summary judgment (Doc. # 76). In its memorandum in support of its motion for partial summary judgment, the plaintiff alleges that the defendants owed the plaintiff a legal duty to disclose material facts and that the defendants failed to disclose those facts (Doc. # 68, pp. 1-2). The defendants deny the plaintiff's allegations in their response (Docs. # 74).

III. STANDARD FOR SUMMARY JUDGMENT

Summary judgment can be entered on a claim only if it is shown "that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law". Fed. R. Civ. P. 56(c). On a motion for summary judgment, the court is to construe the evidence and factual inferences arising therefrom in the light most favorable to the nonmoving party.[5] *Adickes v. S.H. Kress & Co.*, 398 U.S. 144, 158 (1970); *Mize v. Jefferson City Bd. of Educ.*, 93 F.3d 739, 742 (11th Cir.1996).

In responding to a motion for summary judgment, the nonmoving party must do more than restate his conclusory

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[5] The Supreme Court explained that:

> [T]he the plain language of Rule 56(c) mandates the entry of summary judgment, after adequate time for discovery and upon motion, against a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial. In such a situation, there can be "no genuine issue as to any material fact," since a complete failure of proof concerning an essential element of the nonmoving party's case necessarily renders all other facts immaterial.

Celotex Corp. v. Catrett, 477 U.S. 317, 322-23 (1986) (citations omitted).

allegations. Thus, consideration of a summary judgment motion does not lessen the burden on the nonmoving party, i.e., the nonmoving party still bears the burden of coming forth with sufficient evidence on each element that must be proved.[6] *Earley v. Champion Intern. Corp.*, 907 F.2d 1077, 1080 (11th Cir.1990); *see Celotex, 477* U.S. at 322-23.

IV. DISCUSSION

A. Choice-Of-Law

"As a federal court sitting in diversity, we are required to apply the law as declared by the state's highest court." *CSX Transp., Inc. v. Trism Specialized Carriers, Inc.*, F.3d, 1999 WL 536564, *2 (11th Cir.1999) (citing *Erie R.R. Co. v. Tompkins*, 304 U.S. 64, 78 (1938)). Alabama's choice-of-law rules require this court to apply Alabama law to the issues regarding the alleged causes of action based on contract and tort. "Alabama choice of law principles in tort and fraud look primarily to the law of the state where the injury occurs" *Bowling v. Founders Title Co.*, 773 F.2d 1175, 1179 (11th Cir. 1985), *cert. denied sub nom.*

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[6] "[I] f on any part of the prima facie case there would be insufficient evidence to require submission of the case to a jury, . . . [the court must] grant of summary judgment [for the defendant]." *Earley*, 907 F.2d at 1080 (citations omitted). In *Earley*, the Court of Appeals further emphasized:

> "The mere existence of a scintilla of evidence in support of the plaintiff's position will be insufficient; there must be evidence on which the *jury* could reasonably find for the plaintiff." *Anderson, 477* U.S. at 252,106 S.Ct. at 2512.
>
> * * *
>
> If the evidence is merely colorable, or is not significantly probative, summary judgment may be granted." *Anderson*, 477 U.S. at 249-50,106 S.Ct. at 2511 (citations omitted) (emphasis added); *accord Hudson v. Southern Ductile Casting Corp.*, 849 F.2d 1372, 1376 (11th Cir.1988).

Earley, 907 F.2d at 1080-81.

Zoldessy v. Founders Title Co., 475 U.S. 1109 (1986) (citing *Pound v. Gaulding*, 237 Ala. 387,187 So. 468 (1939)). "The general choice-of-law rule in Alabama is *lex loci contractus*, which provides that 'a contract is governed as to its nature, obligation, and validity by the law of the place where it was made.'" *Kruger Commodities, Inc. v. U.S. Fidelity and Guar.*, 923 F.Supp.1474, 1477 (M.D. Ala. 1996) (citing Ex parte Owen, 437 So. 2d 476, 481(Ala.1983) (per curiam)).

B. Applicability of the Employee Retirement Income Security Act ["ERISA"], 29 U.S.C.§ 1003

In their reply memorandum in support of their motion for summary judgement and motion to strike, AMS contends that ERISA preempts the plaintiff's state law claims against it (Doc. # 85, p. 9). The plaintiff alleges that its state law claims are not preempted by ERISA because AMS is not an ERISA entity and the state law claims do not "relate to" the employee benefit plan within the meaning of Section 514(a) of ERISA (Doc. # 89, p.12). According to the plaintiff, the primary reason that the plaintiff's claims do not "relate to" ERISA plan is because AMS is not an ERISA entity.

On the issue of defensive preemption, the Court of Appeals has held that "when a state law claim brought against a non-ERISA entity does not affect relations among principal ERISA entities as such, then it is not preempted by ERISA." *Morstein v. National Ins. Servs., Inc.*, 93 F.3d 715, 722 (11th Cir.1996) (en banc). The Court of Appeals stated that "ERISA entities are the employer, the plan, the plan fiduciaries, and the beneficiaries under the plan" *Id.* at 722 (citations omitted).

AMS contends that it is a Plan fiduciary because the plaintiff delegated to the defendants the fiduciary responsibility to act in the Plan's best interest (Doc. # 85, p.13).

AMS further contends that the plaintiff "gave the defendants, as their agent, *complete discretion* with respect to the administration of its Plan" (Doc. # 85, p. 4) (emphasis in original). However, the plaintiff asserts that AMS is not an ERISA fiduciary because it lacked the exclusive authority to determine eligibility for benefits under the plan and to review denied claims (Doc. # 89, p.10).

Pursuant to 29 U.S.C. § 1002(21)(A):

> a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

Recently, the Court of Appeals has elucidated its position by declaring that "[c]laims administrators are fiduciaries if they have the authority to make ultimate decisions regarding benefits eligibility." *Blue Cross & Blue Shield of Alabama v. Sanders,* 138 F.3d 1347, 1353, n.4 (11th Cir.1998) (citations omitted). See *Engelhardt v. Paul Revere Life Ins. Co.,* 139 F.3d 1346, 1352 (11th Cir. 1998) (holding that the insurance company "is an ERISA fiduciary, and thus an 'ERISA entity,' because it had the exclusive authority to determine eligibility for benefits under the plan and to review denied claims").

The Agreement between AMS and the plaintiff specifically vests "final authority and responsibility for the Plan and its operation" to the plaintiff and not AMS (Doc. # 89, Ex. A, p. 1, ¶a). The Agreement also provides that AMS is to act "as

agent of the PLAN SPONSOR" and perform the duty of claims processing for the Plan (Doc. # 89, Ex. A, p. 2, ¶ a). Under the Agreement, AMS agreed to refer the matters such as any disputed claim and any question of eligibility to the plaintiff for determination (Doc. # 89, Ex. A, p. 2).

"The essential inquiry for a court remains whether [the plaintiff's] claims 'relate to' an ERISA plan." *Mehaffey v. Boston Mut. Life Ins. Co.*, 31 F. Supp. 2d 1329,1335 (M.D. Ala. 1998). AMS contends that each of its alleged "breaches or wrongful acts clearly have a connection with or reference to the Plan inasmuch as a ruling in plaintiff's favor would mean that the Plan would have saved monies or would have excess monies available to the Plan beneficiaries" (Doc. # 85, p.12). The plaintiff contends that "[t]his action is purely a commercial dispute between two businesses and Skilstaf 's state law claims against AMS bear no relationship to the Plan" (Doc. # 89, p.13).

To resolve the issue, the court should "[look] to see whether the state law claims brought by [the plaintiff] have a 'connection with' the ERISA plan." *Morstein v. National Ins. Servs., Inc.*, 93 F.3d at 722 (citing *New York Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995)). In *Mehaffey v. Boston Mut. Life Ins. Co.*, 31 F. Supp. 2d at 1333, Judge Albritton analyzed the issue as follows:

> The Supreme Court has stated that the words "relate to" in ERISA's preemption provision should be broadly construed such that a particular state law claim "relates to" an ERISA plan if the state law claim has a "connection with or reference to" an employee benefit plan. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983). Such a determination must be made with a common sense view of the matter. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 105. S.Ct. 2380, 85

> L.Ed.2d 728 (1985). Even a state law with only an indirect effect on a benefit plan can be preempted unless it affects the plan in "too tenuous, remote, or peripheral a manner." Shaw, 463 U.S. at 100 n. 21,103 S.Ct. 2890.
>
> [8] Claims which are "related to" ERISA plans are those claims which specifically refer to and would affect an ERISA plan, would contravene the structure or purpose of ERISA, would require a construction of the benefit plan, or would mandate an interpretation of the statutory duties of one of the parties to the plan. See *Stoudemire v. Provident Life and Accident Ins. Co.*, 24 F.Supp.2d 1252 (M.D.Ala.1998) *Consumer Benefit Ass'n v. Lexington Ins. Co.*, 731 F.Supp. 1510 1515 (M.D.Ala.1990).

Similarly, in a later case, the Court of Appeals stated that:

> The Supreme Court has held that ERISA does not preempt "run-of-the-mill" claims by non-ERISA entities against ERISA plans, *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 832-33,108 S.Ct. 2182, 2186-87, 100 L.Ed.2d 836 (1988), and thus ERISA a fortiori does not preempt claims by health care providers against a plan fiduciary.

Lordmann Enterprises, Inc. v. Equicor, Inc., 32 F.3d 1529, 1533 (11th Cir. 1994), *cert. denied, 516* U.S. 930 (1995) (citations omitted). Furthermore, "when a state law claim brought against a non-ERISA entity does not affect relations among principal ERISA entities as such, then it is not preempted by ERISA." *Engelhardt v. Paul Revere Life Ins. Co.*, 139 F.3d at 1352.

The applicable case law encourages the conclusion that the plaintiff's suit does not relate to an ERISA plan for two reasons. First, the plaintiff's claims arise from AMS' conduct in its role as a third-party administrator or agent for the

plaintiff.[7] Second, the plaintiff is not seeking damages pursuant to an ERISA plan.[8] Rather, the plaintiff is seeking damages for AMS' alleged failure to process its claims properly.

Therefore, the court rejects AMS' defensive preemption argument because AMS is not an ERISA entity and the state law claims against it do not sufficiently relate to the employee benefit plan to be preempted by ERISA. To the extent that the motion filed by AMS is based upon ERISA preemption, the motion is DENIED.

C. Claims against AMS

1. Breach of contract

The plaintiff's burden on this issue has been articulated by the Alabama Supreme Court. In order to establish that a breach of contract has occurred, a plaintiff must prove:

> "(1) the existence of a valid contract binding the parties in the action, (2) his own performance under the contract, (3) the defendant's nonperformance, and (4) damages." *Southern Medical Health Systems, Inc. v. Vaughn,* 669 So.2d 98, 99 (Ala. 1995) (citations omitted).

Employees' Benefit Ass'n v. Grissett, 732 So. 2d 968, 974 (Ala. 1998). AMS argues that the plaintiff cannot establish all of the elements of a breach of contract claim because the plaintiff cannot show that AMS did not perform its duties under the contract (Doc. # 67, pp. 17-21).

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[7] Because AMS is not an ERISA entity, the plaintiff s claims against it do not affect relations among principal ERISA entities.

[8] The plaintiff paid all outstanding benefits claims that allegedly should have been paid by the defendants; hence, neither the Plan nor the Plan beneficiaries were damaged by the defendants' alleged misconduct (Doc. # 89, p.13). As a result of AMS' actions, the plaintiff was injured.

a. Valid Contract and Plaintiff's Performance

It is undisputed that a valid contract existed and that the plaintiff performed its duties under the Agreement. AMS and the plaintiff entered into an Agreement that is a valid and binding contract between the parties[9] (Doc. # 77, Ex. 3). Moreover, AMS does not even allege that the plaintiff failed to perform its duties under the Agreement (Doc. # 67, p.16-21).

b. The Defendants' Non-Performance: Date of Deletion of Option from Excess Loss Policy

The dispute centers upon the third and fourth elements. First, the plaintiff contends in its amended complaint that AMS did not perform, that is, it breached its contract by:

> (a) failing to use the knowledge, skill, expertise and diligence required in connection with plaintiffs insurance needs; (b) failing to disclose, discuss and

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[9] The Agreement lists AMS's responsibilities as follows:

> WHEREAS, the PLAN SPONSOR has requested AMS to be the Plan Supervisor of the Plan and act as its agent with regard to the payment of certain benefits of the Plan and to furnish certain services with respect to the Plan . . .
>
> * * *
>
> SECTION 2. AMS RESPONSIBILITIES
>
> (a) AMS, as agent of the PLAN SPONSOR, will receive and process claims properly submitted to it under the Plan and will pay Plan benefits in its normal manner subject to and in accordance with this Agreement to or on behalf of persons entitled to receive Plan benefits . . .
>
> * * *
>
> (e) AMS will provide the PLAN SPONSOR with services and assistance in connection with the design and development of the Plan, initially and in connection with Plan revisions.

(Doc. # 77, Ex. 3, pp. 1-2). Pursuant to the Agreement, "AMS will use reasonable care and due diligence in the exercise of its powers in the performance of its duties under this Agreement." (Doc. # 77, p. 4).

> explain the full benefits and effect of the Paid Period Extension Option; (c) failing to include the Paid Period Extension Option in the 1994 and 1995 Policies when it was included in the 1992 and 1993 Policies; (d) unilaterally deleting the Paid Period Extension Option in the 1994 and 1995 Policies without authorization from Stafco; (e) failing to timely process [sic] and pay claims which would have been covered by excess loss policy prior to May, 1996 termination; (f) failing to properly submit [sic] claims to United under the excess loss insurance policy based upon the terms and benefits provided by the Paid Period Extension Option; (g) failure to timely pay [sic] claims to take advantage to provider discounts; (h) taking improper provider discounts either by untimely payments or by taking discounts with providers with whom there were no provider discount agreements; (i) failure to provide administrative services in connection with the Skilstaf drug program; and (j) failure to submit drug claims to United for excess loss coverage.

(Doc. # 32, ¶ 38).

AMS, according to the plaintiff, was contractually obligated to act as its agent (Doc. # 76, p. 21), a conclusion based in part on AMS' representations that it had expertise in this field and that it could adhere to a seven-to-ten-day turnaround time on the payment of claims (Doc. # 77, Ex. 4, Lamb Dep., p.195). In spite of the representations, AMS experienced a severe backlog of claims and failed to pay plaintiff's employees' claims in a proper and timely manner (Doc. # 76, p. 5).

On 16 July 1996, Pam Dombrowski, Technical Consultant for Custom Accounts at AMS, sent the plaintiff a letter stating that "American Medical Security recognizes that a delay has occurred in claim processing while Stafco, Inc.'s contract was in an active status" (Doc. # 77, Ex. 6). David

Lamb ["Lamb"], the plaintiff's employee and agent who placed the plaintiffs coverage with AMS and UWLIC, stated that he received "hundreds of complaints from Skilstaf employees about AMS's failure to process and pay claims in a timely manner" (Doc. # 76, p. 6; Doc. # 77, Ex. 4, Lamb Dep., pp. 27, 112-13, 173-76). To buttress Lamb's contention, the plaintiff submitted sworn statements from various clients who terminated services with the plaintiff as a result of AMS' alleged failure to pay medical claims in a timely and proper manner (Doc. # 76, p. 7-10; Doc. # 77, Exs. 9, 10, 11).

The plaintiff also alleges that, because of the untimely payment of claims, it was deprived of the benefits provided by the Paid Period Extension Option ["Option"]. AMS replied that

> [t]his argument is unavailing as the clear terms of the Option provide that it is only applicable when the Excess Loss Policy is not renewed at the end of a policy term. It would, therefore, only have possibly had application after May 1996 when the policy was terminated.

(Doc. # 67, pp. 18-19) (emphasis in original) (citations omitted).

In his deposition, Lamb testified that the Option from the Excess Loss Policy was removed by the plaintiff and that he believed that this change was done after the first policy year based on the recommendation of Sally Rector (Doc. # 69, Ex. 3, Lamb Dep., p.167-168). Although the first policy year was 1992 (Doc. # 69, Ex. 2), and the next policy year was 1993, the record reflects that the Option was not deleted from the plaintiff's Excess Loss Policy until 1994 (Doc. # 69, Ex. 2, p. 005121).

To be sure, Lamb's testimony is probative of the fact that the plaintiff authorized the deletion of the Option. However, Lamb's lack of specificity regarding the date that the policy was changed, combined with the record evidence that the

change first occurred in the 1994 policy, creates a genuine issue of material fact as to **when** the removal of the Option was requested (emphasis added). Because of this discrepancy, a genuine issue as to material fact may exist as to whether AMS failed to include the Option **in** the 1994 and 1995 policies (emphasis added).

In summary, although Lamb's testimony establishes that AMS did not unilaterally delete the Option, a genuine issue as to material fact exists as to **when** it was done; specifically whether it was done prior to the plaintiff's request (emphasis added).

Notwithstanding the factual discrepancy, AMS contends that coverage of the payment of claims under the Excess Loss Policy is dictated by the terms of the Excess Loss Policy and not the actions of AMS (Doc. # 67, p. 20). "Specifically, the Excess Loss Policy states that if a policy is terminated at any time other than the end of the policy, Aggregate Stop Loss coverage *would not* apply" (Doc. # 67, p. 20) (emphasis in original). Although the clause arguably determines the application of the Aggregate Stop Loss for UWLIC, the clause is silent as to the duration of AMS' liability when a policy is terminated at any time other than the end of the policy. Thus, the court also finds that a genuine factual dispute exists as to whether AMS's liability to the plaintiff terminates when the Excess Loss Policy is terminated prior to the end of the policy.

AMS also alleges that the plaintiff's claims concerning the drug program are meritless because the Agreement did not cover drug claims (Doc. # 67, p. 20). The court agrees. The face of the Agreement belies the plaintiff's drug claims, because it clearly states that prescription drugs and birth control pills are "[n]ot Covered" (Doc. # 69, Ex. 1, p. 00049); hence the court's finding that there is no genuine and material factual dispute regarding this issue. AMS had no contractual duty to provide administrative services in connection with the

plaintiffs drug program and to submit drug claims to UWLIC for excess coverage. AMS's motion for summary judgment is GRANTED as to the plaintiff's allegations regarding coverage of drug claims, namely the claims recited in subparagraphs (i) and (j) of Paragraph 38 in the Amended Complaint.

c. Damages

In opposition to the plaintiff's claim that it was damaged, AMS argues that the terms of the Agreement limit AMS' liability: "AMS will not be liable for any mistake of judgment or other action taken in good faith." (Doc. # 69, Ex. 1, p. 00042). Thus, it should not be held liable for breach of contract because its liability is limited.

AMS' argument is not responsive to the plaintiff's claim that it incurred damages. That AMS' liability was limited does not negate the plaintiff's sufferance of non-covered claims and claims for which payment was substantially delayed. Accordingly, even if the court accepted AMS' analysis and concluded the issue of its liability in AMS' favor, that finding would not conclude — and perhaps not even touch — the existence of plaintiffs damages. Moreover, notwithstanding the contractual provision, considering the evidence as a whole and in a light favorable to the plaintiff, the court also finds that a genuine issue of material fact exists as to whether AMS' acted in good faith. To the extent that the motion for summary judgment applies to the plaintiff's claim for damages, it is therefore DENIED.

In summary, on the issue of breach of contract, the court grants the defendants' motion for summary judgment on the claims recited in subparagraphs (i) and (j) of Paragraph 38 in the Amended Complaint. In all other respects, AMS' motion for summary judgment as the plaintiff's breach of contract claim is denied.

2. Negligence and Wantonness

To establish negligence, a plaintiff must prove that the defendant owed the plaintiff a duty, that the defendant breached that duty, and that the breach proximately caused the plaintiff to be injured or damaged. *Martin v. Arnold,* 643 So.2d 564, 567 (Ala. 1994). "To establish wantonness, the plaintiff must prove that the defendant, with reckless indifference to the consequences, consciously and intentionally did some wrongful act or omitted some known duty. To be actionable, that act or omission must proximately cause the injury of which the plaintiff complains." *Id.* at 567 (citations omitted).

The plaintiff contends that AMS owed a duty to perform its services properly and to fulfill its responsibilities as the third-party administrator, advisor, and consultant to the plaintiff and that AMS was negligent and wanton in the performance of services and duties (Doc. # 32, ¶¶ 41-42, 51). The plaintiff contends that as a proximate result of AMS' negligent acts, it was damaged (Doc. # 32, ¶ 44).

AMS contends that the plaintiff's claims of negligence and wantonness are mere restatements of its breach of contract claim, that "[t]he gravamen of plaintiff's complaint is *ex contractu*" (Doc. # 67, p. 21) (emphasis in original). Because its duties to the plaintiff arise solely from the Agreement, AMS alleges that the plaintiff has "failed to establish any independent or distinguishable basis for any duty AMS may owe to the plaintiff (Doc. # 67, p.21).

The evidence discloses facts upon which the trier of fact could accept a plausible argument in favor of negligence in this case. Independent of the agreement, AMS' duties to the plaintiff could have arisen from other representations that it made to the plaintiff. The FlexFunding brochure provided by AMS stated that "[i]n short . . . we investigate, subrogate and negotiate to keep your claims cost in line" (Doc. # 77, Ex. 1).

AMS also advertised that its "[p]ayment of claims is more prompt than most insurers" (Doc. # 77, Ex. 1). In his deposition testimony, Lamb stated that the plaintiff selected AMS as its third-party administrator based upon its representations that it had superior knowledge and expertise as a third-party administrator in the health benefits field (Doc. # 77, Ex. 24, pp. 50,195).

Because a genuine issue as to material facts exist as to whether AMS negligently breached non-contractual duties to the plaintiff, AMS's motion for summary judgment on the claims of negligence and wantonness is denied.

3. Fraud

To establish fraudulent suppression, a plaintiff must establish:

> "(1) that the defendant had a duty to disclose a material fact; (2) that the defendant either failed to disclose or concealed that material fact; (3) that the defendant's failure to disclose or his concealment of that material fact induced the plaintiff to act or to refrain from acting; and (4) that the plaintiff suffered damage as a result of his action, or inaction, induced by the defendant's failure to disclose or his concealment of the material fact."

Blackburn v. Fidelity & Deposit Co. of Maryland, 667 So.2d 661, 673 (Ala. 1995) (quoting *Soniat v. Johnson-Rast & Hays*, 626 So.2d 1256, 1258-59 (Ala. 1993)). However, if the plaintiff receives from the defendant documents that put him on notice of the very facts alleged to have been suppressed, then that defendant cannot have suppressed those facts. *Robinson v. JMIC Life Ins. Co.*, 697 So.2d 461, 462 (Ala. 1997).

a. The Paid Period Extension Option

The plaintiff contends that AMS failed to disclose and suppressed the full benefits and effect of the Paid Period

Extension Option (Doc. # 32, ¶ 54a). However, Lamb, the plaintiff's employee, testified in his deposition that the Option was explained to him at the initial sale of the policy (Doc. # 69, Ex.3, Lamb Dep., p.126-27). Furthermore, the plaintiff 19 received an initial Policy and three renewal polices that explained the Option (Doc. # 69, Ex. 2).

Because the plaintiff received documents that put him on notice of the very facts alleged to have been suppressed, the court finds that the plaintiff had sufficient notice or knowledge of the Option and had thus has no claim for suppression of that fact. See *Robinson v. JMIC Life Ins. Co.*, 697 So.2d at 462; see *also Henson v. Celtic Life Ins. Co.*, 621 So.2d 1268 *(Ala.1993)*. Accordingly, the court grants AMS's motion for summary judgment as it relates to claim (a) of paragraph 54 in the Amended Complaint (Doc. # 32, ¶ 54a).

b. Excess Claim Payments in 1992 and 1993

The plaintiff contends that AMS failed to disclose and suppressed the fact that the plaintiff's claim payments exceeded the stop-loss attachment point in both 1992 and 1993 by application of the extended paid period as provided for in the Paid Period Option (Doc. # 32, ¶ 54b). AMS alleges that "[t]he policy issued to the plaintiff clearly states that the Paid Period Extension Option can only be exercised if the Excess Loss Policy is terminated" (Doc. # 67, p. 25; Doc. # 69, Ex. 2, 00018). Because the plaintiff renewed its Policy in 1992 and 1993, the Paid Period Extension Option had no application to those years (Doc. # 69, Ex. 2).

Again, the plaintiff received documents that put him on notice of the very facts alleged to have been suppressed, and the court accordingly finds that the plaintiff had sufficient knowledge that the 1992 and 1993 claims exceeded the stop-loss-attachment point. See *Robinson v. JMIC Life Ins. Co.*, 697 So.2d at 462; see also *Henson v. Celtic Life Ins. Co.*, 621

So.2d at 1268. AMS' motion for summary judgment as it relates to claim (b) of paragraph 54 in the Amended Complaint (Doc. # 32, ¶54b).

c. Excessive Claim Payments in 1994 and 1995

The plaintiff contends that AMS failed to disclose and suppressed the fact that its claim payments exceeded the stop loss attachment point in both 1994 and 1995 as a consequence of AMS' failure to submit drug claims to UWLIC (Doc. # 32, ¶ 54c). The Agreement between AMS and the plaintiff does not cover drug claims (Doc. # 69, Ex. 2, p. 00049).

In 1993, the plaintiff amended its Policy and terminated all drug coverage for its employees (Doc. # 69, Ex. 7). Therefore, the plaintiff was not entitled to excess loss coverage in 1994 and 1995 for drug charges because the plaintiff's Plan did not provide such coverage to its employees. Consequently, the court finds that there is no genuine issue of fraud on this issue, because, in any case, AMS had no duty to submit drug claims to UWLIC.

The court grants AMS' motion for summary judgment as it relates to claim (c) of paragraph 54 in the Amended Complaint (Doc. # 32, ¶54c).

In summary, the court grants AMS's motion for summary judgment as it relates to the plaintiff's entire fraudulent suppression claim against it as found in Paragraph 54 of the Amended complaint (Doc. # 32, ¶ 54).

4. Breach of fiduciary duty

The Alabama Supreme Court has stated that:

> The law is well settled in Alabama and other jurisdictions that an agent owes his principal a fiduciary duty and therefore must act in the utmost good faith and must make known to his principal all material facts within his knowledge that in any way affect the transaction and the subject matter of the agency. *Myers*

> *v. Ellison, 249* Ala. 367, 31 So.2d 353 (1947). If an agent represents two principals without fully disclosing that dual representation to both of the principals, the resulting transaction is usually voidable by either of the principals. *Barker v. First Nat'l Bank, 20 F.Supp. 185,190* (N.D.Ala.1937); *See also, 3* C.J.S. Agency § 277 (1973).

Bay Shore Properties, Inc. v. Drew Corp., 565 So.2d 32, 34 (Ala. 1990).

The plaintiff contends AMS breached its fiduciary relationship that existed between them. (Doc. # 32, ¶ 48). AMS admits that it "recognizes that certain fiduciary duties arise with reference to the Plan under the Employee Retirement Income Security Act" (Doc. # 67, p. 21). Although AMS admits that it owes fiduciary duties to *the Plan and its participants,* AMS contends that it does not owe such duties *to the plaintiff* (Doc. # 67, p. 21).[10]

The Alabama Supreme Court has defined a fiduciary or confidential relationship as:

> " '[Such a relationship is one in which] one person occupies toward another such a position of adviser or counselor as reasonably to inspire confidence that he will act in good faith for the other's interests, or when one person has gained the confidence of another and purports to act or advise with the other's interest in mind; where trust and confidence are reposed by one person in another who, as a result, gains an influence or superiority over the other; and it appears when the circumstances make it certain the parties do not deal on equal terms, but, on the one side, there is an overmastering influence, or, on the other, weakness,

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[10] On this, AMS claims that for purposes of defensive ERISA preemption, it is a fiduciary. However, AMS argues that it is not a fiduciary to the plaintiff at all.

> dependence, or trust, justifiably reposed; in both an unfair advantage is possible. It arises in cases in which confidence is reposed and accepted, or influence acquired, and in all the variety of relations in which dominion may be exercised by one person over another.' "15A C.J.S. Confidential (1967)."

K& C Development Corporation v. AmSouth Bank, N.A., 597 So.2d 671, 675 (Ala. 1992) (citing *Bank of Red Bay v. King*, 482 So.2d 274, 284 (Ala. 1985)).

The plaintiff has represented that its selection of AMS as its third-party administrator was based on AMS' representations that it had superior knowledge and expertise as a third-party administrator in the health benefits field (Doc. # 68, Ex. 9, Lamb Dep., pp. 50, 195; Doc. # 77, Ex. 1). In the agreement, AMS represented itself to be the plaintiff's agent and to provide the plaintiff "with services and assistance in connection with the design and development of the Plan, initially and in connection with Plan revisions." (Doc. # 77, Ex. 3, pp. 1-2).

AMS agreed to "use reasonable care and due diligence in the exercise of its powers in the performance of its duties under this Agreement." (Doc. # 77, p. 4). According to the plaintiff, it considered AMS to be its agent, consultant, expert, and advocate in administering its health benefits plan and in procuring excess loss insurance coverage for the partially self-insured plan (Doc. # 68, Ex. 8, Stark Dep., pp.143,180-81).

Based upon the evidence submitted by the parties, the existence of a fiduciary or confidential relationship between the plaintiff and AMS and the duties which flowed from that relationship are in substantial dispute. Accordingly, court denies AMS's motion for summary judgment on the plaintiff's claim of breach of fiduciary duty.

D. Claims against UWLIC

1. Breach of contract

The plaintiff asserts that UWLIC breached its contract by refusing and failing to make payment to the plaintiff pursuant to the Policy (Doc. # 32, ¶ 59). UWLIC contends that the plaintiff cannot establish that a breach of contract occurred because the plaintiff failed to comply with the terms of their contract (Doc. # 67, p. 9).

It is undisputed that a contract existed between the parties (Doc. # 69, Ex. 2). The key issue is whether the second element of a breach of contract claim has been shown. The Policy states that "UWLIC shall have no obligation to pay any Aggregate Excess Loss Insurance if this Policy terminates during the Policy Term" (Doc. # 69, Ex. 2, 00009).

The plaintiff admits that it received the Policy and the renewal Policies (Doc. # 69, Ex. 4, Stark Dep., p. 112). The plaintiff also admits that it terminated the Policy with UWWIC before the end of the policy term (Doc. # 32, ¶ 30; Doc. # 69, Ex. 6). Consequently, the plaintiff cannot show that it performed its duties as listed in the Policy. The court therefore grants UWLIC's motion for summary judgment on the plaintiff's breach of contract claim.

2. Bad faith

In *Ex Parte Government Employees Ins. Co.*, 729 So.2d 299, 306 (Ala. 1999), the Alabama Supreme Court stated the elements of a bad-faith claim:

> "[T]he plaintiff in a 'bad faith refusal' case has the burden of proving:
>
> "(a) an insurance contract between the parties and a breach thereof by the defendant;
>
> "(b) an intentional refusal to pay the insured's claim;

> "(c) the absence of any reasonably legitimate or arguable reason for that refusal (the absence of a debatable reason);
>
> "(d) the insurer's actual knowledge of the absence of any legitimate or arguable reason;
>
> "(e) if . . . intentional failure to determine the existence of a lawful basis is relied upon, the plaintiff must prove the insurer's intentional failure to determine whether there is a legitimate or arguable reason to refuse to pay the claim.
>
> "In short, plaintiff must go beyond a mere showing of nonpayment and prove a bad faith nonpayment, a nonpayment without any reasonable ground for dispute. Or, stated differently, the plaintiff must show that the insurance company had no legal or factual defense to the insurance claim." *Id.* at 183. See also *Employees' Benefit Association v. Grissett*, [Ms. 1961766, September 11, 1998]—So.2d—(Ala. 1998), and *Chavers v. National Sec. Fire & Cas. Co.*, 405 So.2d 1 (Ala. 1981).

(citing *National Sec. Fire & Cas. Co. v. Bowen*, 417 So.2d 179 (Ala. 1982)).

In addition to setting the aforementioned elements of the claim, the Alabama Supreme Court has held that "mere negligence or mistake is not sufficient to support a claim of bad faith; there must be a refusal to pay, coupled with a conscious intent to injure." *Id.* at 306 (citations omitted).

There is no evidence UWLIC's decision not to pay was based on any factor other than the clear language of the Excess Loss Policy, i.e., that "UWLIC shall have no obligation to pay any Aggregate Excess Loss Insurance if this Policy terminates during the Policy Term" (Doc. # 69, Ex. 2, 00009). Inasmuch as the plaintiff terminated the Policy during the Policy term (Doc. # 69, Ex. 6), at least one of the

elements necessary for a bad-faith claim is absent, i.e., the requirement that the insurer have no legitimate or arguable basis for denying the claim. See *Ex Parte Government Employees Ins. Co.*, 729 So.2d 299 at 306. Accordingly, the court grants UWLIC's motion for summary judgment on the plaintiff s bad faith claim.

3. Fraudulent Suppression

The plaintiff contends that UWLIC failed to disclose and suppressed the full benefits and effect of the Paid Period Extension Option (Doc. # 32, ¶ 64a). The plaintiff also contends that UWLIC failed to disclose and suppressed the fact that the plaintiffs claim payments exceeded the stop-loss attachment point in light of the extended paid period provided for by the Option (Doc. # 32, ¶ 64b).

This claim is concluded against the plaintiff by reference to the court's analysis of and finding on the same claim against AMS, infra. See *Robinson v. JMIC Life Ins. Co.*, 697 So.2d at 462; *see also Henson v. Celtic Life Ins. Co.*, 621 So.2d at 1268. Accordingly, the court grants UWLIC's motion for summary judgment on the claims recited in subparagraphs (a) and (b) of paragraph 64 in the Amended Complaint (Doc. # 32, ¶ 64a, b).

The plaintiff contends that UWLIC failed to disclose and suppressed the fact that the drug claims paid by the plaintiff, if calculated in connection with the claims submitted to UWLIC, also caused the plaintiff to exceed the stop-loss attachment point (Doc. # 32, ¶ 54c). In 1993, the plaintiff amended its Policy and terminated all drug coverage for its employees (Doc. # 69, Ex. 7). Therefore, the plaintiff was not entitled to excess loss coverage in 1994 and 1995 for drug charges because the plaintiff's Plan did not provide such coverage to its employees. For reasons already articulated herein, the court grants UWLIC's motion for summary judgment on the plaintiff's claim recited in subparagraph (c)

of paragraph 64 in the Amended Complaint (Doc. # 32, ¶ 64c).

V. CONCLUSION

For the reasons articulated in this order, it is hereby ORDERED that the motion for summary judgment filed by the defendants, American Medical Security, Inc., and United Wisconsin Life Insurance Company, on 10 May 1999 (Doc. # 66) be GRANTED in part and DENIED in part. Accordingly, it is the further ORDER, JUDGMENT, and DECREE of this court that:

1. The motion is GRANTED as to the following claims: (a) fraud by AMS, (b) breach of contract by AMS as it relates to claims (i) and (j) of Paragraph 38 in the Amended Complaint; (c) breach of contract by UWLIC, (d) bad faith by UWLIC, and (e) fraud by UWLIC.

2. The motion is DENIED as to the following claims: (1) breach of contract by AMS, except with regard to claims (i) and (j) of paragraph 38 in the Amended complaint; (2) negligence by AMS; (3) wantonness by AMS; and (4) breach of fiduciary duty by AMS.

It is further ORDERED that the trial of this case, which is set to commence by 23 August 1999, will proceed only on the plaintiff's claims against defendant American Medical Services, Inc., specifically (1) breach of contract, (2) negligence, (3) wantonness, and (4) breach of fiduciary duty, as more fully described in this order.

The Clerk of the Court is DIRECTED to forward copies of this order to counsel of record via facsimile.

DONE this 20th day of August 1999.

/s/ Vanztta Penn McPherson
VANZTTA PENN MCPHERSON
UNITED STATES MAGISTRATE JUDGE

APPENDIX G

STATUTORY PROVISIONS

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

§ 3. Definitions

For purposes of this title:

* * * *

(21) (A) Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. Such term includes any person designated under §405(c)(1)(B).

(B) If any money or other property of an employee benefit plan is invested in securities issued by an investment company registered under the Investment Company Act of 1940, such investment shall not by itself cause such investment company or such investment company's investment adviser or principal underwriter to be deemed to be a fiduciary or a party in interest as those terms are defined in this title, except insofar as such investment company or its investment adviser or principal underwriter acts in connection with an employee benefit plan covering employees of the investment company, the investment adviser, or its principal underwriter. Nothing contained in this

subparagraph shall limit the duties imposed on such investment company, investment adviser, or principal underwriter by any other law.

* * * *

§ 404. Fiduciary Duties

(a) Prudent Man Standard of Care.

(1) Subject to §§ 403(c) and (d), 4042, and 4044, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

(C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this title and title IV.

* * * *

§ 406. Prohibited Transactions

* * * *

(b) Transactions Between Plan and Fiduciary. A fiduciary with respect to a plan shall not—

(1) deal with the assets of the plan in his own interest or for his own account,

(2) in his individual or in any other capacity act in any transaction involving the plan on behalf of a party (or represent a party) whose interests are adverse to the interests of the plan or the interests of its participants or beneficiaries, or

(3) receive any consideration for his own personal account from any party dealing with such plan in connection with a transaction involving the assets of the plan.

* * * *

§ 502. Civil Enforcement

(a) Persons Empowered to Bring Civil Action. A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under § 409;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 105(c);

(5) except as otherwise provided in subsection (b), by the Secretary (A) to enjoin any act or practice which violates any provision of this title, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this title;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), or (6) of subsection (c) of this section or under subsection (i) or (l) of this section;

(7) by a State to enforce compliance with a qualified medical child support order (as defined in §609(a)(2)(A));

(8) by the Secretary, or by an employer or other person referred to in section §101(f)(1), (A) to enjoin any act or practice which violates subsection (f) of §101, or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; or

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.

* * * *

§ 503. Claims Procedure

In accordance with regulations of the Secretary, every employee benefit plan shall—

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

* * * *

§ 514. Other Laws

(a) Supersedure; Effective Date. Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in § 4(a) and not exempt under § 4(b). This section shall take effect on January 1, 1975.

(b) Construction and Application.

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in § 4(a), which is not exempt under § 4(b) (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under

such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under § 506 of this Act.

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(5)(A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section—

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after the date of the enactment of this paragraph), but the Secretary may enter into cooperative arrangements under this paragraph and

§506 with officials of the State of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded by such parts 1 and 4 and the preceding sections of this part.

(6)(A) Notwithstanding any other provision of this section—

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides—

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this title, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this title.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of

arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of § 3(1) and § 4 necessary to be considered an employee welfare benefit plan to which this title applies.

(C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this title apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.

(7) Subsection (a) shall not apply to qualified domestic relations orders (within the meaning of § 206(d)(3)(B)(i)), qualified medical child support orders (within the meaning of § 609(a)(2)(A)), and the provisions of law referred to in § 609(a)(2)(B)(ii) to the extent they apply to qualified medical child support orders.

(8) Subsection (a) of this section shall not be construed to preclude any State cause of action—

(A) with respect to which the State exercises its acquired rights under § 609(b)(3) with respect to a group health plan (as defined in § 607(1)), or

(B) for recoupment of payment with respect to items or services pursuant to a State plan for medical assistance approved under title XIX of the Social Security Act which would not have been payable if such acquired rights had been executed before payment with respect to such items or services by the group health plan.

(9) For additional provisions relating to group health plans, see §731.

(c) Definitions. For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this title.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of the United States prohibited. Nothing in this title shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in §§ 111 and 507(b)) or any rule or regulation issued under any such law.

REGULATIONS

29 C.F.R. § 2560.503-1—Claims Procedure

(a) Scope and purpose.

(1) This section sets out certain minimum requirements for employee benefit plan procedures pertaining to

claims by participants and beneficiaries (claimants) for plan benefits, consideration of such claims, and review of claim denials, hereinafter referred to in the aggregate as "claims procedures." Except as otherwise noted, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Employee Retirement Income Security Act of 1974 (the Act).

(b) Obligation to establish a reasonable claims procedure. Every employee benefit plan shall establish and maintain reasonable claims procedures.

(1) A claims procedure will be deemed to be reasonable only if it:

(i) Complies with the provisions of paragraphs (d) through (h) of this section, except to the extent that it is deemed to comply with some or all of such provisions under the authority of paragraph (b)(2) or paragraph (j) of this section.

(ii) Is described in the summary plan description, as required by § 2520.102-3,

(iii) Does not contain any provision, and is not administered in a way, which unduly inhibits or hampers the initiation or processing of plan claims, and

(iv) Provides for informing participants in writing, in a timely fashion, of the time limits set forth in paragraphs (e)(3) and (g)(3) and paragraph (h) of this section.

(2) In the case of a plan established and maintained pursuant to a collective bargaining agreement (other than a plan subject to the provisions of section 302(c)(5) of the Labor Management Relations Act, 1947 concerning joint representation on the board of trustees):

(i) Such plan will be deemed to comply with the provisions of paragraphs (d) through (h) of this section if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference.

(A) Provisions concerning the filing of benefit claims and the initial disposition of benefit claims, and

(B) A grievance and arbitration procedure to which denied claims are subject.

(ii) Such plan will be deemed to comply with the provisions of paragraphs (g) and (h) of this section (but will not be deemed to comply with paragraphs (d) through (f)) if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference a grievance and arbitration procedure to which denied claims are subject (but not provisions concerning the final and initial disposition of benefit claims).

(c) Claims procedure for an insured welfare or pension plan.

(1) To the extent that benefits under an employee benefit plan are provided or administered by an insurance company, insurance service, or other similar organization which is subject to regulation under the insurance laws of one or more States, the claims procedure pertaining to such benefits may provide for filing of a claim for benefits with and notice of decision by such company, service or organization.

(2) See paragraph (g) regarding review and final decision on denied claims by insurance companies, insurance services and similar organizations.

(d) Filing of a claim for benefits. For purposes of this section, a claim is a request for a plan benefit by a participant or beneficiary. A claim is filed when the requirements of a reasonable claim filing procedure of a plan have been met. If a reasonable procedure for filing claims has not been established by the plan, a claim shall be deemed filed when a written or oral communication is made by the claimant or the claimant's authorized representative which is reasonably calculated to bring the claim to the attention of:

(1) In the case of a single employer plan, either the organizational unit which has customarily handled employee benefits matters of the employer, or any officer of the employer.

(2) In the case of a plan to which more than one unaffiliated employer contributes, or which is established or maintained by an employee organization, either the joint board, association, committee or other similar group (or any member of any such group) administering the plan, or the person or organizational unit to which claims for benefits under the plan customarily have been referred.

(3) In the case of a plan the benefits of which are provided or administered by an insurance company, insurance service, or other similar organization, which is subject to regulation under the insurance laws of one or more States, the person or organizational unit which handles claims for benefits under the plan or any officer of the insurance company, insurance service, or similar organization.

(4) For purposes of paragraphs (d)(1), (2), and (3) of this section, a communication shall be deemed to have been brought to the attention of an organizational unit if it is received by any person employed in such unit.

(e) Notification to claimant of decision.

(1) If a claim is wholly or partially denied, notice of the decision, meeting the requirements of paragraph (f) of this section, shall be furnished to the claimant within a reasonable period of time after receipt of the claim by the plan.

(2) If notice of the denial of a claim is not furnished in accordance with paragraph (e)(1) of this section within a reasonable period of time, the claim shall be deemed denied and the claimant shall be permitted to proceed to the review stage described in paragraph (g) of this section.

(3) For purposes of paragraphs (e)(1) and (2), of this section, a period of time will be deemed to be unreasonable if it exceeds 90 days after receipt of the claim by the plan, unless special circumstances require an extension of time for processing the claim. If such an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the final decision.

(f) Content of notice. A plan administrator or, if paragraph (c) of this section is applicable, the insurance company, insurance service, or other similar organization, shall provide to every claimant who is denied a claim for benefits written notice setting forth in a manner calculated to be understood by the claimant:

(1) The specific reason or reasons for the denial;

(2) Specific reference to pertinent plan provisions on which the denial is based;

(3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and

(4) Appropriate information as to the steps to be taken if the participant or beneficiary wishes to submit his or her claim for review.

(g) Review procedure.

(1) Every plan shall establish and maintain a procedure by which a claimant or his duly authorized representative has a reasonable opportunity to appeal a denied claim to an appropriate named fiduciary or to a person designated by such fiduciary, and under which a full and fair review of the claim and its denial may be obtained. Every such procedure shall include but not be limited to provisions that a claimant or his duly authorized representative may:

(i) Request a review upon written application to the plan;

(ii) Review pertinent documents; and

(iii) Submit issues and comments in writing.

(2) To the extent that benefits under an employee benefit plan are provided or administered by an insurance company, insurance service, or other similar organization which is subject to regulation under the insurance laws of one or more States, the claims procedure pertaining to such benefits may provide for review of and decision upon denied claims by such company, service or organization. In such case, that company, service, or organization shall be the "appropriate named fiduciary" for purposes of this section. In all other cases, the "appropriate named fiduciary" for purposes of this section may be the plan

administrator or any other person designated by the plan, provided that such plan administrator or other person is either named in the plan instrument or is identified pursuant to a procedure set forth in the plan as the person who reviews and makes decisions on claim denials.

(3) A plan may establish a limited period within which a claimant must file any request for review of a denied claim. Such time limits must be reasonable and related to the nature of the benefit which is the subject of the claim and to other attendant circumstances. In no event may such a period expire less than 60 days after receipt by the claimant of written notification of denial of a claim.

(h) Decision on review.

(1)(i) A decision by an appropriate named fiduciary shall be made promptly, and shall not ordinarily be made later than 60 days after the plan's receipt of a request for review, unless special circumstances (such as the need to hold a hearing, if the plan procedure provides for a hearing) require an extension of time for processing, in which case a decision shall be rendered as soon as possible, but not later than 120 days after receipt of a request for review.

(ii) In the case of a plan with a committee or board of trustees designated as the appropriate named fiduciary, which holds regularly scheduled meetings at least quarterly, a decision on review shall be made by no later than the date of the meeting of the committee or board which immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a decision may be made by no later than the date of the second meeting following the plan's receipt of the request

for review. If special circumstances (such as the need to hold a hearing, if the plan procedure provides for a hearing) require a further extension of time for processing, a decision shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review.

(2) If such an extension of time for review is required because of special circumstances, written notice of the extension shall be furnished to the claimant prior to the commencement of the extension.

(3) The decision on review shall be in writing and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, as well as specific references to the pertinent plan provisions on which the decision is based.

(4) The decision on review shall be furnished to the claimant within the appropriate time described in paragraph (h)(1) of this section. If the decision on review is not furnished within such time, the claim shall be deemed denied on review.

(i) Apprenticeship plans. This section does not apply to employee benefit plans which provide solely apprenticeship training benefits.

(j) Qualified health maintenance organizations. Claims procedures with respect to any benefits provided through membership in a qualified health maintenance organization, as defined in section 1310(d) of the Public Health Service Act, as amended, 42 U.S.C. 300e-9(d), shall be deemed to satisfy the requirements of this section with respect to the provision of such benefits to persons who are members of such qualified health maintenance organization, provided those procedures meet the requirements of section 1301 of the Public Health Service Act, as amended 42 U.S.C. 300e and the regulations thereunder.